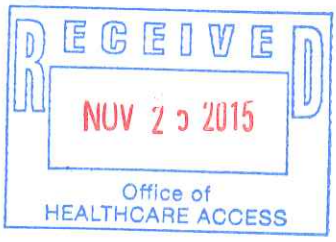
Saint Mary's HOSPITAL

Trinity Health New England

Trinity Health Livonia, MI

November 25, 2015

Via Hand Delivery




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

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

Dear Ms. Martone,

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

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

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

Respectfully submitted,

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

By: _____
Chad W. Wable
President and CEO

Trinity Health – New England, Inc.

By: _____
Christopher M. Dadlez
President and CEO

Trinity Health

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

# Checklist

**Instructions:**

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

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

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

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

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

☒ Attached is a completed Financial Attachment

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

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

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

---

**For OHCA Use Only:**

**Docket No.:** 15-32045-CON **Check No.:** 394110
**OHCA Verified by:** SU **Date:** 11/25/15

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

# RepublicanAmerican

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

| PAYMENT TERMS | 30 DAYS |
|---|---|
| TOTAL AMOUNT DUE | $ 410.64 |

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

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

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

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

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

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

RECEIVED
NOV 11 2015
CHAD WABLE

**Past due balance accrues finance charge of 1.5% per month**

**All charges include any applicable Connecticut State sales tax**

**REMITTANCE ADVICE - PLEASE RETURN WITH PAYMENT**

**REMITTANCE ADDRESS**

**REPUBLICAN AMERICAN**
**PO BOX 2090**
**WATERBURY, CT 06722-2090**

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

| | |
|---|---|
| CREDIT CARD # | |
| EXPIRATION DATE | |
| SIGNATURE | |

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

| CHECK # | |
|---|---|

# RepublicanAmerican

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

## Classified Advertising Proof

**Account Number:** 75401
**Order Number:** RA0695501

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

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

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

NOTICE

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

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114 Woodland St.
Hartford, CT 06105

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

**Total Order Price: $410.64**

**Please call or send an email by 3pm to approve or to make changes.**
**(No call back will result in your ad running as it appears on this proof.)**
Advertisements placed on CTJobs.com, AfterCollege.com and Recruitment Networks run for 30 days

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

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

Vendor #16676
TREASURER STATE OF CT OAK ST WKRS CO

№ 394110

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

PAYMENT AMT: 500.00

Saint Mary's HOSPITAL

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

№ 394110

51-7010/2111

DATE
11/23/2015

CHECK AMOUNT
***500.00***

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

PAY TO THE ORDER OF TREASURER STATE OF CONNECTICUT

TREASURER STATE OF CONNECTICUT
55 ELM ST
HARTFORD, CT 06106

TWO SIGNATURES REQUIRED IF OVER $50,000.00

Saint Mary's HOSPITAL

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


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| | | |
|---|---|---|
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# State of Connecticut
# Department of Public Health
# Office of Health Care Access

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## Certificate of Need Application
## Main Form
***Required for all CON applications***

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**Contents:**


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

## All Supplemental Forms

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

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

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

# General Information

| Main Site* | MAIN SITE PFI | MEDICAID PROVIDER ID | TYPE OF FACILITY | MAIN SITE NAME |
|---|---|---|---|---|
| | N/A | Inpatient – 004041760<br>Outpatient- 004025060 | Hospital | Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. |
| | STREET & NUMBER | | | |
| | 56 Franklin Street | | | |
| | TOWN | | ZIP CODE | |
| | Waterbury, CT | | 06706 | |

*For additional sites

| Project Site | PROJECT SITE PFI | MEDICAID PROVIDER ID | TYPE OF FACILITY | PROJECT SITE NAME |
|---|---|---|---|---|
| | N/A | IP -<br>OP- | Hospital | Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. |
| | 56 Franklin Street | | | |
| | | | | |
| | TOWN | | ZIP CODE | |
| | Waterbury, CT | | 06706 | |

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

| Chief Executive | NAME | | TITLE | |
|---|---|---|---|---|
| | Christopher Dadlez | | President and CEO<br>Trinity Health – New England, Inc. | |
| | STREET & NUMBER | | | |
| | 114 Woodland Street | | | |
| | TOWN | | STATE | ZIP CODE |
| | Hartford | | CT | 06105 |
| | TELEPHONE | FAX | E-MAIL ADDRESS | |
| | 860-714-5541 | 860-714-7920 | cdadlez@stfranciscare.org | |

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

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

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

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

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

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

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

**AFFIDAVIT**

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

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

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

Signature

11/23/15
Date

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

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

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

**AFFIDAVIT**

Applicant: **Trinity Health**

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

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

Signature

11·25·2015
Date

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

Claudia A. Crane

Notary Public/Commissioner of Superior Court

My commission expires: 11-17-2019

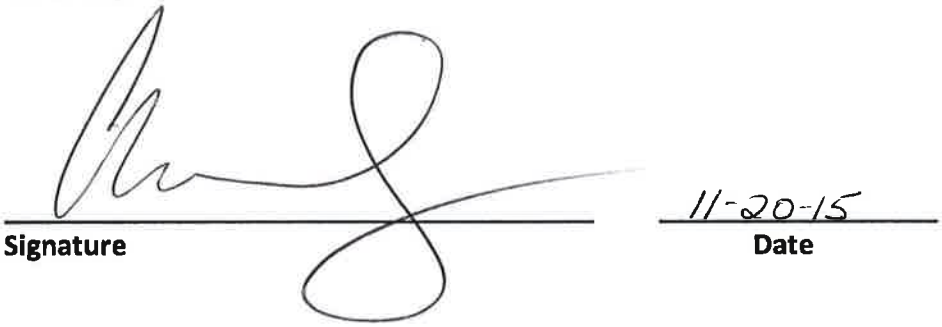
Claudia A. Crane, Notary Public
State of Michigan, County of Oakland,
My Commission Expires 11/17/2019
Acting in the County of _____

**AFFIDAVIT**

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

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

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



**Signature** 11-20-15 **Date**

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

Janeanne Christina Rubin-Scafuzzi, Esq.

**Notary Public/Commissioner of Superior Court**

**My commission expires:** _____

## Executive Summary

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

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

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

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

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

## Project Description

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

**The Parties**

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

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

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

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

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

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

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

Trinity Health

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

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

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

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

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

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

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

## The Proposal

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

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

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

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

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

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

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

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

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

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

Waterbury service area;

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

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

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

**Need for the Proposal in the Community**

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

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

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

1, below.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**3. Provide the following information:**

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

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

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

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

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

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

No new licenses are being sought in this CON application.

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

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

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

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

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

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

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

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

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

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

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

d. **letters of support for the proposal;**

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

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

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

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

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

**Public Need and Access to Care**

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

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

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

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

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

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

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

The Transfer Agreement between SMHS, NE-RHM and Trinity Health is consistent with the *Statewide Health Care Facilities and Services Plan* (the "Plan") published by the Connecticut Department of Public Health's Office of Health Care Access ("OHCA") in October of 2012 and supplemented in 2014. The Transfer Agreement between the three parties is clearly aligned with the premise of the Plan. Section 1.4 of the Guiding Principles 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 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. (Plan at, p. 2.)

As the Plan makes clear, as of 2012, OHCA was aware 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) By 2014, the supplement to the Plan listed the corporate affiliations that have already occurred in Connecticut. Becoming part of a larger health care system such as Trinity Health will aid SMHS in developing economies of scale when purchasing supplies and services, and will also improve access to capital. These factors, in turn will allow SMHS to improve the quality of care that is required by the 2010 Patient Protection and Affordable Care Act ("PPACA").

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 are key drivers in today's health care environment. Connecticut hospitals are pursuing 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 SMHS to make needed capital improvements, invest in new technology and continue to be a safety net provider in the Greater Waterbury region.

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

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

The PPACA requires hospitals to improve quality of care delivered to patients through a variety of means such as improving infection control programs and 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). Trinity Health, as a national provider of health care, is aware of these requirements and has the ability to share best practices among its member hospitals, and has already provided evidence at its existing facilities of improving infection control programs and reducing readmissions. This proposal promotes Population Health Management which is a system that emphasizes 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. Trinity Health has experience with 88 hospitals and provides an environment that SMHS's physicians and other providers across the continuum of care can utilize to provide access to evidence-based practices. These practices will improve quality and patient safety, enhance efficiency through uniform productivity and financial management, and develop integrated information systems.

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

**a. identify the target patient population to be served;**

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

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

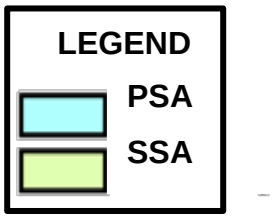


**Table 1** provides a summary of the population of the service area from 2000 projected to 2020. The City of Waterbury (a PSA for the Hospital) is projected to experience a 4.9% increase in population from 2010 to 2020. A population increase of 5.5% is projected for the 12 town secondary service area.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

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

**Table 1: Total Population 2000 – 2020**

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

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

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

**Table 2: Age Distribution Primary Service Area**

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

*Source: CERC, 2014*

**Table 3: Age Distribution Secondary Service Area**

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

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

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

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

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

**Table 4: Socio/Economic Data**

| Town | Poverty Rate* | Household Income* | Unemployment rate** | Median Age* |
|---|---|---|---|---|
| **Primary Service Area** | | | | |
| Naugatuck | 8.6% | $62,574 | 9.4% | 39 |
| Prospect | 3.2% | $95,325 | 6.7% | 44 |
| Waterbury | 21.9% | $40,867 | 12.5% | 35 |
| Wolcott | 3.4% | $80,655 | 7.8% | 44 |
| **Secondary 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 | 6.6% | 44 |
| Morris | 5.6% | $89,688 | 5.9% | 45 |
| Oxford | 4.5% | $107,308 | 6.4% | 45 |
| Plymouth | 6.7% | $73,603 | 8.9% | 41 |
| Southbury | 6.4% | $67,195 | 6.6% | 50 |
| Southington | 3.6% | $78,668 | 6.4% | 44 |
| Thomaston | 2.7% | $67,426, | 7.8% | 43 |
| Watertown | 3.4% | $80.899 | 7.7% | 44 |
| Woodbury | 4.6% | $80,167 | 5.9% | 48 |
| **Connecticut** | **10.0%** | **$69,519** | **7.8%** | **40** |

**2012*

*** 2013*

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

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

currently provides.

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

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

*Cardiovascular services*

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

*Surgical services*

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

*Medical services*

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

*Women and Infant services*

- Obstetrics
- Neonatology (Level 2 NICU)

*Behavioral Health*

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

*Emergency Department*

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

*Imaging Services*

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

*Interventional Radiology*

- Angiography
- Biopsies
- Stent Placement

*Breast Care*

- Stereotactic breast biopsies
- Breast ultrasound

*Other Outpatient Programs*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**h. explain how access to care will be affected;**

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

**i. discuss any alternative proposals that were considered.**

Please refer to Question 2.

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

**9. Describe how the proposal will:**

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

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

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

offers graduate medical education programs in:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Through the UCO, Trinity Health is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Financial Information**

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

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

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

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

group purchasing savings.

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

Saint Francis Health*Care* Partners:

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

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

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

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

Foundation of our Contracting Model:

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

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

CMS Medicare ACO:

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

Current Contracts:

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

Value-Based Commercial Agreements:

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

Covered Lives: 82,000

Value-based Medicare Advantage Agreements:

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

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

Focus on the Future for SMHS:

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

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

**Cost Containment Protocols**

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

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

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

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

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

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

## 2. Materials Management

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

financing and provider supply.

**3. Charity Care**

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

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

Please refer to table 3 below**.**

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

This question is not applicable.

**17. Include as an attachment:**

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

Please refer to **Exhibit 22.**

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

Please refer to **Exhibit 17**.

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

Please refer to Table 4 below.

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

Please refer to **Exhibit 17**

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

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

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

This question is not applicable.

**Utilization**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The existing referral patterns will remain unchanged.

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

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

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

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

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

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

## Tables

### TABLE 1
### APPLICANT'S SERVICES AND SERVICE LOCATIONS

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

This table is not applicable.

### TABLE 2
### SERVICE AREA TOWNS

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

| Town* | Reason for Inclusion |
|---|---|
| | |

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

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

**TABLE 3**
**TOTAL PROPOSAL CAPITAL EXPENDITURE**

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

*** If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.**
**** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.**
***** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.**

This table is not applicable.

**TABLE 4**
**PROJECTED INCREMENTAL REVENUES AND EXPENSES**

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

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

**TABLE 5**
**HISTORICAL UTILIZATION BY SERVICE**

**SMHS**

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

**Trinity Health - New England**

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

1. Fiscal Year is October - September.

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

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

**TABLE 6**
**PROJECTED UTILIZATION BY SERVICE**

**SMHS**

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

**Trinity Health – New England**

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

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

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

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

**TABLE 7**
**APPLICANT'S CURRENT & PROJECTED PAYER MIX**
**SMHS**

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

**Trinity Health-New England**

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

**Assumptions:**

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

*** 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.**

**TABLE 8**
**UTILIZATION BY TOWN**

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

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

**TABLE 9**
**SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS**

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

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

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

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

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

**AFFIDAVIT**

Applicant: **Trinity Health**

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

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

Signature

11·25·2015
Date

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

Claudia A. Crane

Notary Public/Commissioner of Superior Court

My commission expires: 11-17-2019

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

**AFFIDAVIT**

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

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

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

_____ 11-20-15

**Signature** **Date**

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

Janeanne Christina Rubin-Scafuzzi, Esq.

**Notary Public/Commissioner of Superior Court**

**My commission expires:** _____

**AFFIDAVIT**

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

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

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

Signature _____ Date 11/23/15

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

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

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

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

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

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

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

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

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

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

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

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

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

      ii. **Governance or controlling body.**

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

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

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

## 2. Historical and Projected Volume

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

**TABLE A**
HISTORICAL AND CURRENT DISCHARGES

**SMHS**

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

**Trinity Health - New England**

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

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

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

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

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

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

## TABLE B
## HISTORICAL AND CURRENT PATIENT DAYS

### SMHS

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

### Trinity Health - New England

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

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

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

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

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

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

**TABLE C**

**PROJECTED DISCHARGES BY SERVICE**

**SMHS**

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

**TRINITY HEALTH - NEW ENGLAND, INC.**

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

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

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

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

## TABLE D
## PROJECTED PATIENT DAYS BY SERVICE

### SMHS

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

### Trinity Health – New England Inc.

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

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

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

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

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

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

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

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

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

**3. Clear Public Need**

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

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

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

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

**4. Supplemental Questions**

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

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

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

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

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

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

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

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

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

Access to Care Initiatives

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

Mental Health and Substance Abuse Initiatives

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

Obesity and Chronic Diseases Initiatives

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

Tobacco Use Initiatives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

See **Exhibit S3**

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

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

See **Exhibit S4**

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

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

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

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

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

**Monthly Financial Measurement/Indicators**

Refer to **Exhibit 17**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Communication and Language Assistance*:

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

*Engagement, Continuous Improvement, and Accountability*:

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

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

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

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

Saint Mary's HOSPITAL

# Certificate of Need

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# EXHIBIT 1

**Saint Mary's Hospital Awards and Accomplishments**

**2013**

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

**2014**

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

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

**2015**

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

cleverley+associates

## *2015 Community Value Leadership Award Winner*

# Community Value Five-Star®

Saint Marys Hospital

# EXHIBIT 2

Healthcare Transformation Task Force Members

March 19, 2015

## Providers Members

Advocate Health Care

Aledade

Ascension

Atrius Health

Dartmouth-Hitchcock Health

Dignity Health

Evolent Health

Heritage Provider Network

Optium

OSF Healthcare

Partners Healthcare

Premier

Providence Health & Services

SLL Health

SSM Health

Trinity Health

Tuscan Medical Center

## Payers Members

Aetna

Blue of California

HCSC Health Care Service Corporation

Blue Cross Blue Shield Massachusetts

## Purchasers Members

Caesars Entertainment

PBGH Pacific Business Group in Health

## Patients and Families Members

National Partnership for Women and Families

## Partners Members

The Dartmouth Institute

Mark McClellan, Brookings Institute

Patientping

remedy partners

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

# EXHIBIT 3

Execution Copy

# TRANSFER AGREEMENT

**by and among**

**SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION**

**and**

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

**Dated as of September 18, 2015**

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## TRANSFER AGREEMENT

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

## RECITALS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## ARTICLE I
### DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## ARTICLE II
## TRANSFER

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

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

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

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

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

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

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

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

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

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

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

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

**Section 3.09 Community Benefit.**

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

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

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

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

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

**Section 3.11 Debt and Long-Term Liabilities.**

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

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

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

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

## ARTICLE IV
## CAPITAL COMMITMENT

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

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

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

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

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

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

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

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

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

## ARTICLE V
## CLOSING

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

**Section 5.02 Closing Deliverables.**

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

(i) [Reserved];

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## ARTICLE VI
### REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

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

**Section 6.01 Organization and Corporate Authority.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Section 6.09 Material Contracts.**

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

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

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

(iii) all Contracts with any Governmental Authority;

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

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

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

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

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

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

(ii) any managed care agreements;

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

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

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

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

**Section 6.10 Title to Saint Mary's Assets.**

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

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

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

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

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

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

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

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

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

**Section 6.12 Real Property.**

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

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

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

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

**Section 6.13 Intangible Personal Property; Software.**

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

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

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

**Section 6.14 Legal Proceedings; Governmental Orders.**

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

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

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

**Section 6.15 Compliance with Laws; Permits.**

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

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

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

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

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

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

**Section 6.16 Medicare Participation/Accreditation**

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

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

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

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

**Section 6.17 Compliance Programs**

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

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

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

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

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

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

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

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

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

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

**Section 6.21 Environmental Matters.**

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

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

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

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

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

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

**Section 6.22 Employee Benefit Matters.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Section 6.23 Employment Matters.**

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

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

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

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

**Section 6.24 Taxes.**

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

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

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

**Section 6.25 Insurance. Schedule 6.25** of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the "**Saint Mary's Insurance Policies**"); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

**Section 6.26 Medical Staff.** SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

**Section 6.27 Brokers.** Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

**Section 6.28 Due Diligence.** Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

**Section 6.29 Full Disclosure.** No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

**Section 6.30 No Other Representations and Warranties.** Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

## ARTICLE VII
### REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

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

**Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.**

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

**Section 7.02 Tax-Exempt Status.** Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

**Section 7.03 Authorization and Enforceability of this Agreement.** The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

**Section 7.04 No Conflicts; Consents.** The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

**Section 7.05 Brokers.** Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

**Section 7.06 Legal Proceedings.** There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

**Section 7.07 Financial Statements.**

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

**Section 7.08 Compliance with Laws; Permits.**

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

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

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

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

**Section 7.09 Medicare Participation/Accreditation**

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

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

**Section 7.10 Compliance Programs**

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

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

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

**Section 7.11 Corporate Integrity Agreements.** Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

**Section 7.12 HIPAA.** To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12**.

**Section 7.13 Financial Capacity.** NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

**Section 7.14 Due Diligence.** NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

**Section 7.15 Full Disclosure.** No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

**Section 7.16 No Other Representations and Warranties.** Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

## ARTICLE VIII
## COVENANTS

**Section 8.01 Conduct of Operations Prior to the Effective Date.**

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

**Section 8.02 Regional Strategy/Structure and Integration Plan.** As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

**Section 8.03 Access to Information.**

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

**Section 8.04 Efforts to Consummate.** Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

**Section 8.05 Updated Financial Statements.** Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06.** The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

**Section 8.06 Employment Matters.**

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

**Section 8.07 Insurance.**

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

**Section 8.08 Title and Survey Matters.**

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

**Section 8.09 Transfer Taxes.** All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

**Section 8.10 Public Announcements.** Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

**Section 8.11 Confidentiality.**

(a) "**Confidential Information**" means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a "**Disclosing Party**") or its Representatives to the other Party (a "**Recipient**") and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term "**Confidential Information**" does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

**Section 8.12 Updated Disclosure Schedules.** Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

**Section 8.13 Further Assurances.** Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

**Section 8.14 No Shop.** The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

## ARTICLE IX
## CONDITIONS TO CLOSING

**Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health.** The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or 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 Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

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

**Section 9.02 Conditions Precedent to Obligations of Saint Mary's.** The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or 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 NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

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

## ARTICLE X
## TERMINATION

**Section 10.01 Termination.** This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

**Section 10.02 Effect of Termination.** In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X, Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

## ARTICLE XI
### MISCELLANEOUS

**Section 11.01 Survival.** None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

**Section 11.02 Expenses.** Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

**Section 11.03 Notices.** All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

<u>If to Saint Mary's</u>
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

<u>With a copy to:</u>
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

**Section 11.04 Interpretation.** For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

**Section 11.05 Headings.** The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

**Section 11.06 Severability.** If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

**Section 11.07 Entire Agreement.** This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

**Section 11.08 Successors and Assigns.** This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

**Section 11.09 No Third Party Beneficiaries.** This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

**Section 11.10 Amendment and Modification; Waiver.** This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

**Section 11.11 Governing Law; Submission to Jurisdiction.** This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

**Section 11.12** **Specific Performance.** The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

**Section 11.13** **Counterparts.** This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

**SIGNATURE PAGE FOLLOWS**

**IN WITNESS WHEREOF,** and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

**SAINT MARY'S HEALTH SYSTEM, INC.**

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

**TRINITY HEALTH CORPORATION**

By: _____

Name: James R. O'Connell

Title: Executive Vice President

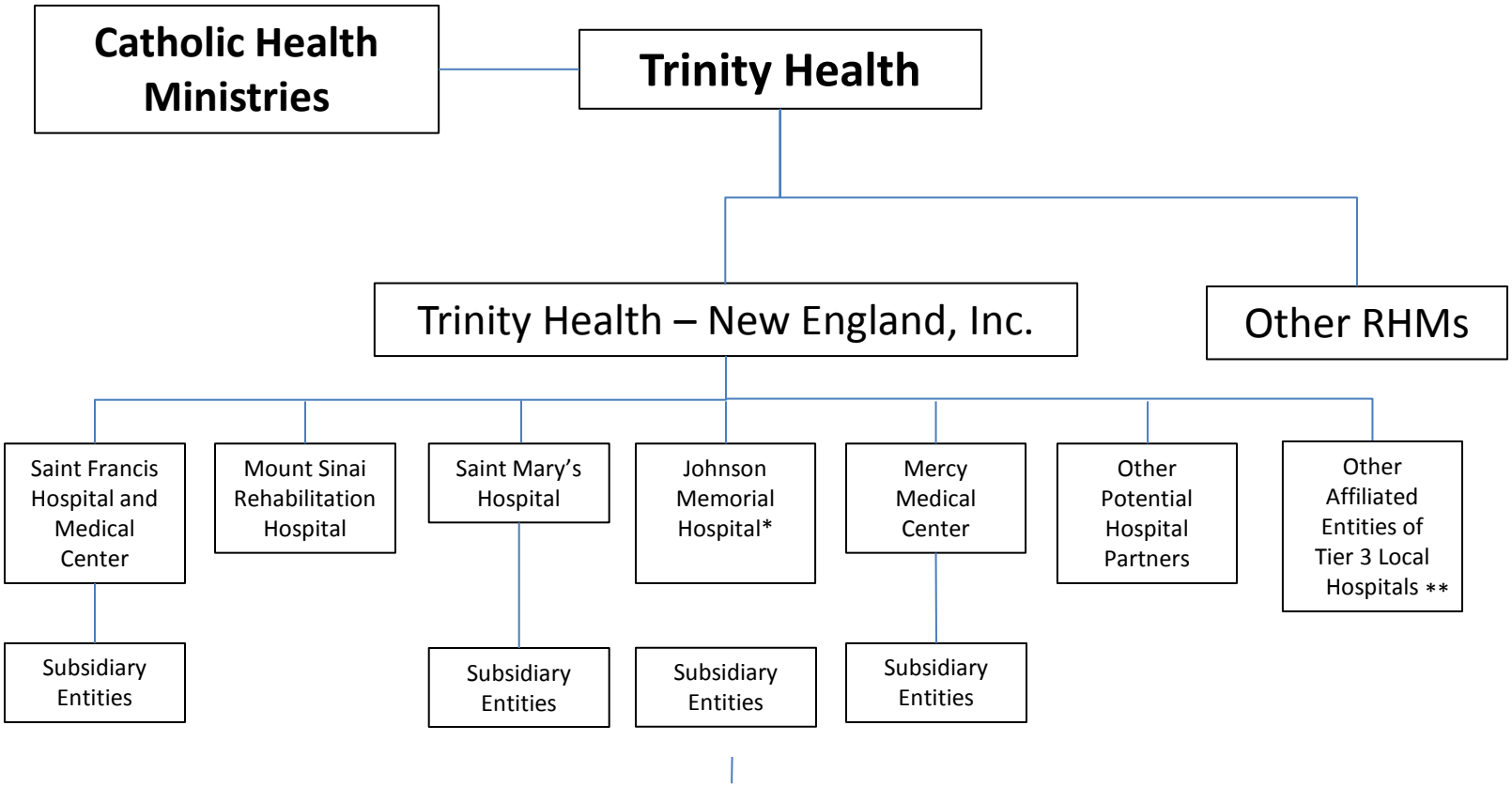
**SAINT FRANCIS CARE, INC.**

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

# EXHIBIT 4




*(1/1/2016 anticipated closing date)

** This refers to non-hospital entities that are on the same level as the hospital entities noted, such as Saint Francis Medical Group, Inc., Saint Francis Hospital Foundation, etc.

# EXHIBIT *5*

# Saint Mary's Strategic Plan 2016-2020

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# Introduction and overview

Saint Mary's HEALTH SYSTEM

# Introduction and Overview

The materials included in this document represent an update to the existing plan that was created last year. The strategies are rooted in our mission (which remains unchanged) and our vision, but have been fine tuned to reflect what we have learned and how the environment has evolved.

In 2014, our physicians, staff and community helped to craft a plan for 2015-2019 which contemplated advancing population health, establishing a Clinically Integrated Network and Accountable Care Organization and investing in Ambulatory care.

After living with it for nearly a year, we wanted to fine tune and continue to focus on the core elements of the plan. We have taken the time to incorporate suggestions from our physicians, staff and community on how to ensure that we are focused on the appropriate initiatives given the evolving healthcare climate both at Saint Mary's and regionally. Substantive change was made in the service line initiatives so that we are more focused and appropriating resources to successfully execute these initiatives.

We have also spent the year contemplating joining a system of regional/national health systems with the belief that joining the Regional Health Ministry will accelerate successful achievement of the plan. Saint Mary's is also focusing on Trinity's Healthy 2020 health wellness vision.

# Strategic Plan Process

Saint Mary's HEALTH SYSTEM

# 2016 Drivers of Strategic Plan

**Payer Activity**

1. Payer consolidation
2. Accountable care reimbursement changes like bundled payment plans and value based purchasing
3. Increasing demand for transparency
4. Payment models changing to reflect cost and/or quality

**Provider Activity**

1. Non traditional competition
2. Physician alignment and integration
3. Ongoing consolidation and partnerships of CT healthcare providers (hospitals, physician groups)

**Consumer Activity**

1. Growth in high deductible plans
2. Consumer directed choices (with assistance from upstarts/payers)
3. Increasingly interested in ratings adding to confusion of what they mean
4. Growing demand for convenient outpatient services as inpatient activity decreases

# Mission and Values

Saint Mary's Health System provides excellent healthcare in a spiritually enriched environment to improve the health of our community.

## "I Care" Values

- Integrity
- Caring
- Accountability
- Respect
- Excellence

# Our vision (updated for 2016-2020)

Saint Mary's will become an integrated network of healthcare providers creating exceptional value for those we serve through trusted partnerships that empower and transform lives.

# Overall strategy & initiatives

Saint Mary's HEALTH SYSTEM

# Overall strategy

"Build the wall" – Provide care to our community within our network of trusted providers.

Saint Mary's HEALTH SYSTEM

# Strategic Initiatives

## Strengthen the Core

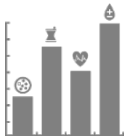
Drive continued, sustainable improvement in operations focusing on Quality & Safety, Service, Healthy People, and Financial Discipline

## Cultivate a Clinically Integrated Network

Establish a team of care coordinators, strategic partnerships, structure, and support mechanisms to achieve a clinically integrated network, with coordinated care across our ecosystem

## Service Line Strategy

Create comprehensive Cardiac and Primary Care service line strategy that encompasses the complete continuum of a patient's care allowing for leading levels of quality, service and efficiency



## Signature Services Strategy Development

New!

Develop a laser focus on patient outcomes and experience, viewing the patient experience in a contemporary, collaborative manner with all care provided regardless of the patient's point-of-entry

## Ambulatory Care Network

Create a network where every patient has access to primary care, urgent care, basic imaging and blood draw within 10 minutes of anywhere in our market

# Strengthen the Core

- The core focuses on transforming our culture around the following:
  - Quality & Safety (Preventable harm & Core Quality Indicators)
  - Patient & Family Centered Service (Wait times & Satisfaction Scores)
  - Healthy & Engaged People (Health & Wellness)
  - Financial Discipline (Efficiency, Productivity, Revenue)

# Strengthen the Core

## SHORT TERM (1-2 YEAR) INITIATIVES

### Healthy & Engaged People

- Design and implement a comprehensive wellness plan
- Design and implement a comprehensive workforce development plan

### Quality & Safety

- Reduce Preventable Harm
- Improve Core Quality

### Patient & Family Centered Service

- Improve the ED front end intake process
- Eliminate waiting throughout the system
- Transform services towards a Retail Orientation
- Fully optimize the patient feedback system

### Financial Discipline

- Continue to improve productivity management
- Enhance cost management across the system
- Reduce overall fixed costs
- Revenue optimization

## LONG TERM (3-5 YEAR) INITIATIVES

- Leverage the regional health ministry to enhance and improve all core initiatives.

# Develop a Clinically Integrated Network

**SHORT TERM (1-2 YEAR) INITIATIVES**

- Creating the CIN structure
- Growing the attributed lives through physician alignment
- Develop and finalize payer contracting initiatives
  - MSSP
  - Anthem
  - Cigna
- Using data to improve care management
- Decrease clinical variation amongst CIN providers
- Prepare for regional system integration

**LONG-TERM (3-5 YEAR) INITIATIVES**

- Evolve payer contracts to risk based models
- Developing the care management models

# Service Lines

Focus on Cardiac and Primary Care service lines because:

- Leverage existing service lines that have an organizational structure in place, will drive system revenue and increase market share
- Grow the number of attributed lives while preparing for the shift to population health management
- Support the Ambulatory Care Network Strategy through having primary care be one of the anchors for the access centers

# Why these Two Service Lines?

## Primary Care

- Foundation of referrals into the system
- Primary Care equals market share and controlling your market share
- Panel size vs. IP admissions
- Hub of the care team

## Cardiac

- Strong foundation currently in place
- Currently provide a full range of services
- Market share is strong in a competitive market
- Relatively high margin for surgical procedures

# Primary Care Service Lines

***Goal is by 2020 to have a well managed population with 65,000 attributed lives***

Short Term (1-2 Year) Initiatives

- Achieve a PCMH Level 1 designation for FMG
- Create a unifying branding approach
- Continue to recruit primary care providers to either FMG or VHA
- Open 2 Centers collocating with urgent care, x-ray, lab and specialists
- Created a referral management improvement process

Long Term (3-5 Year) Initiatives

- Create a consistent patient experience regardless of location
- Open 3 more Outpatient Centers
- EHR upgrade to allow for expedited data sharing, scheduling and integration
- Achieve a Patient Centered Medical Neighborhood designation

Focus Areas

- Retail strategy
- Smart growth
- Access

# Cardiac Service Line

***Goal is to increase market share to equal overall Saint Mary's market share***

Short Term (1-2 Year) Initiatives

- Organic Growth across all services
- Continued development of the Electrophysiology ("EP") Program
- Expand access to services
- Provider recruitment and retention

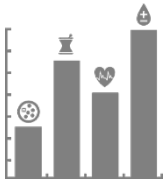
Long Term (3-5 Year) Initiatives

- Maintain a competitive edge through ensuring contemporary technology
- New service growth
- Improve quality and efficiency

Focus areas

- Outpatient growth
- Reduce outmigration
- Enhancing programs for patient convenience

# Signature Services



**Services that are strategic in nature and play a supporting role in the overall strategy. Work continues on them as planned.**

**Surgical Services**

- Bariatric
  - Leverage the Centers of Excellence designation
  - Grow volume through additional provider capacity and capabilities
  - Evolve to a weight management program
- Robotic & Minimally invasive surgery
- Ambulatory surgery
  - Co-Management with NVSC

**Neuro Spine**

- Spine Surgery
- Head and Neck
- Co-management

**Women's Services**

- Focus on the Spirt of Women program
- Grow the Women's and Infants service

**Emergency Department**

- Reduce the front end wait
- Continue to implement the redesign of patient flow

# Key Strategic Clinical Services in Development

*Following services are in a planning and development stage and will be further refined within the year.*

**Oncology**

- Need to leverage Smillow and Leever market awareness
- Comprehensive Breast Strategy
- Cancer patients require a holistic approach to care along the whole continuum
- Diagnosis, treatment and survivorship can last up to 7 years with higher utilization of health services

**Orthopedics**

- High margin, in demand
- Current pieces are fragmented both in care delivery and patient experience
- Comprehensive Care for Joint Replacement ("CCJR") CMS bundled payment here
- Comprehensive rotator cuff bundled program and total joint center are potential opportunities
- Explore demand for sports medicine and concussion clinics

# Develop an Ambulatory Care Network (2016)

Create a network where every patient has access to primary care, urgent care, imaging, blood draw and specialists within 10 minutes of anywhere in our market

**DEFINING PRINCIPLES**

- Network of ambulatory services with access points throughout our service area
- Positioned to be consumer driven for “vertical” patients
- Primary Care, Urgent Care, Imaging, Lab and Specialist’s offices are the core
- Develop strong brand identity and customer experience
- Located in retail corridors

# Develop an Ambulatory Care Network

**SHORT TERM (1-2 YEAR) INITIATIVES**

- Continue to open our access centers (Primary Care, Urgent Care, Imaging, Lab, Specialist Space) in key strategic areas
- Transform occupational medicine towards corporate wellness
- Complete a feasibility plan for an ambulatory pavilion connected to Saint Mary's Hospital
- Complete master partnership with NVRA with go--no go decision
- Optimize medical space throughout the health system

# Develop an Ambulatory Care Network

**LONG-TERM (3-5 YEAR) INNITIATIVES**

- Establish 5-7 ambulatory care centers in the market including primary care, urgent care, imaging and blood draw
- If feasible, build an ambulatory care pavilion connected/adjacent to Saint Mary's Hospital
- Explore development of a Digestive Disorders Center including GI
- Explore development of a Medical Fitness and Wellness strategy in conjunction with physical and occupational therapy
- Explore development of a Women’s breast center
- Create a comprehensive Cardiac Center

# EXHIBIT 6

# 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

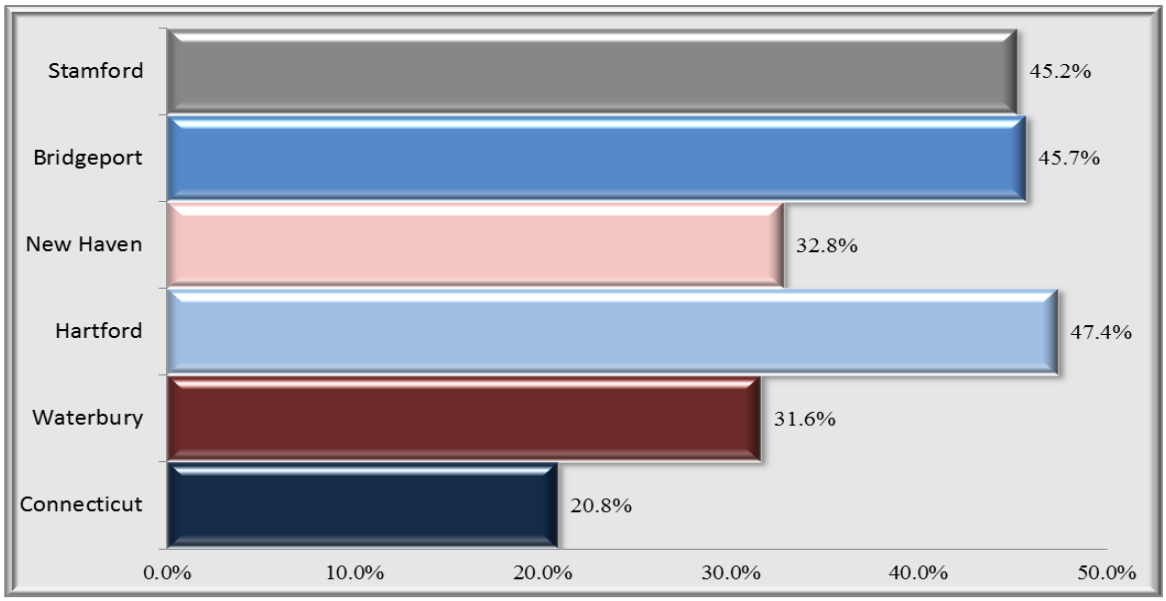



Figure 1. Percentage of population speaking a language other than English, 2009-2011
Source: U.S. Census Bureau, 2012

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).

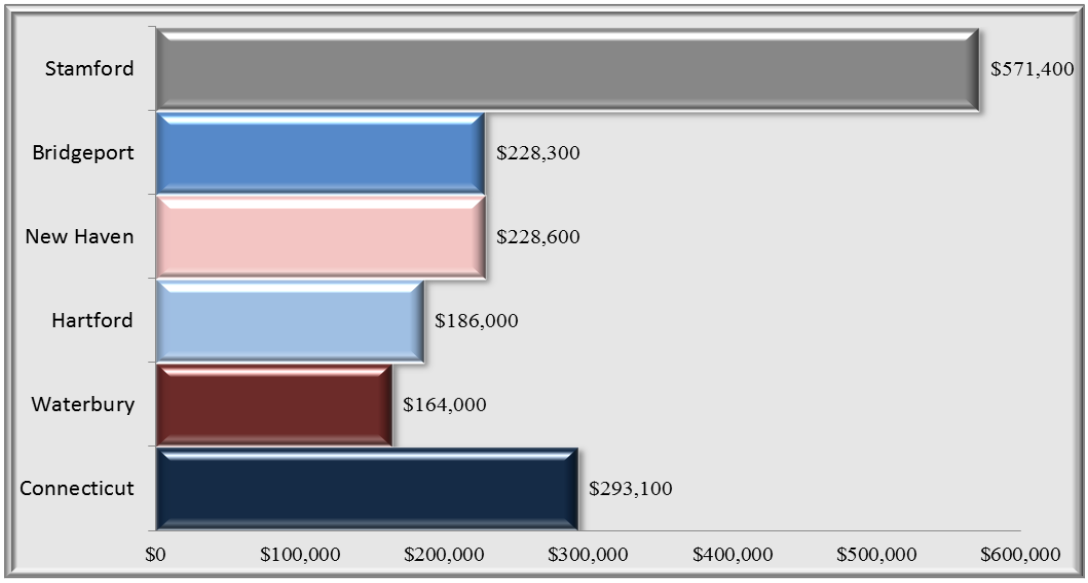



Figure 2. Median value for owner-occupied unit, 2009-2011
Source: U.S. Census Bureau, 2012

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).

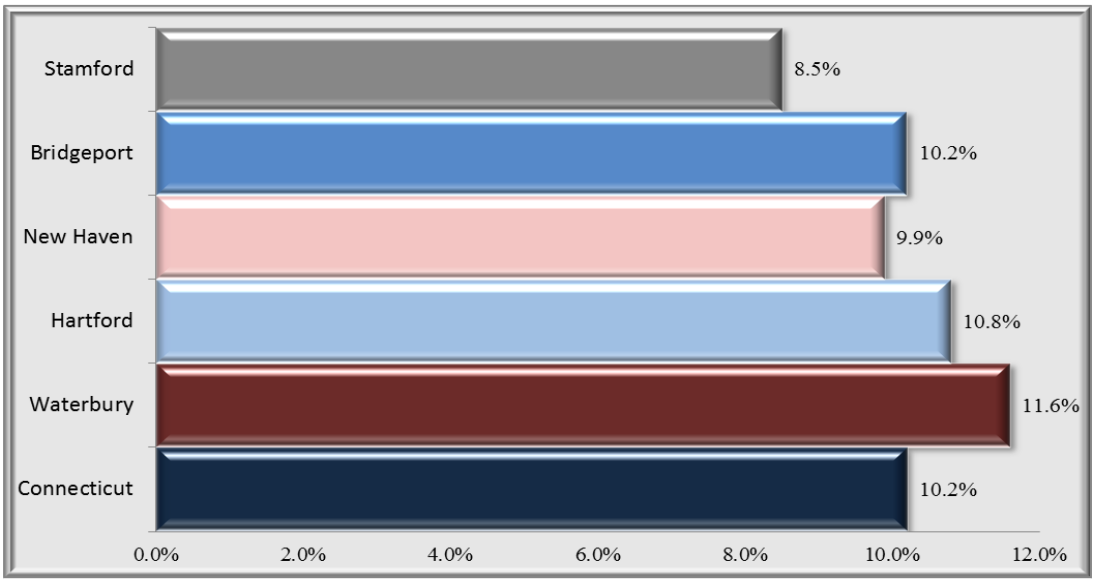



Figure 3. Divorce Rate, 2009-2011
Source: U.S. Census Bureau, 2012

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.).

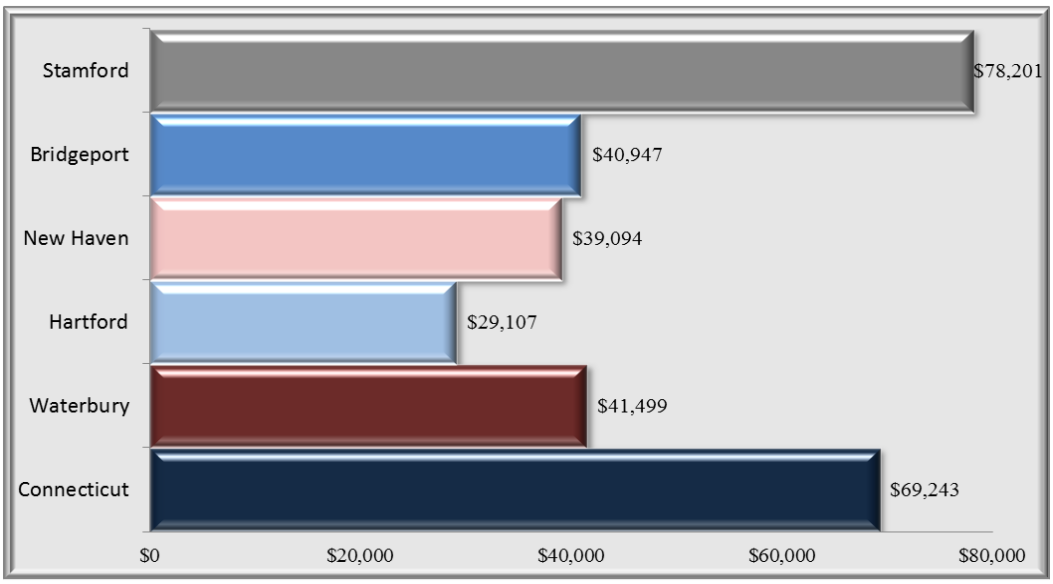



Figure 4. Median household income, 2009-2011
Source: U.S. Census Bureau, 2012

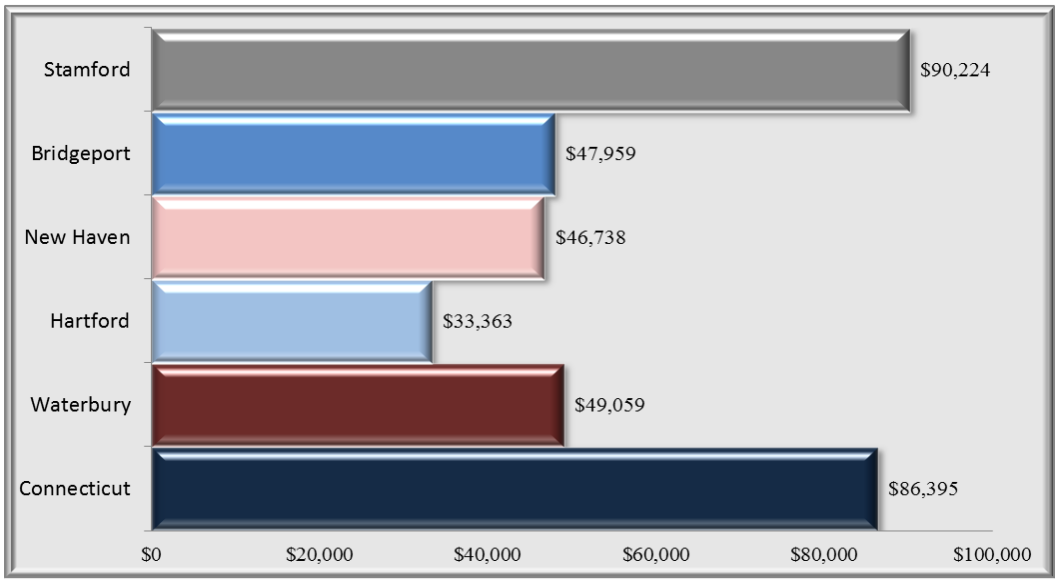



Figure 5. Median family income, 2009-2011
Source: U.S. Census Bureau, 2012

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.

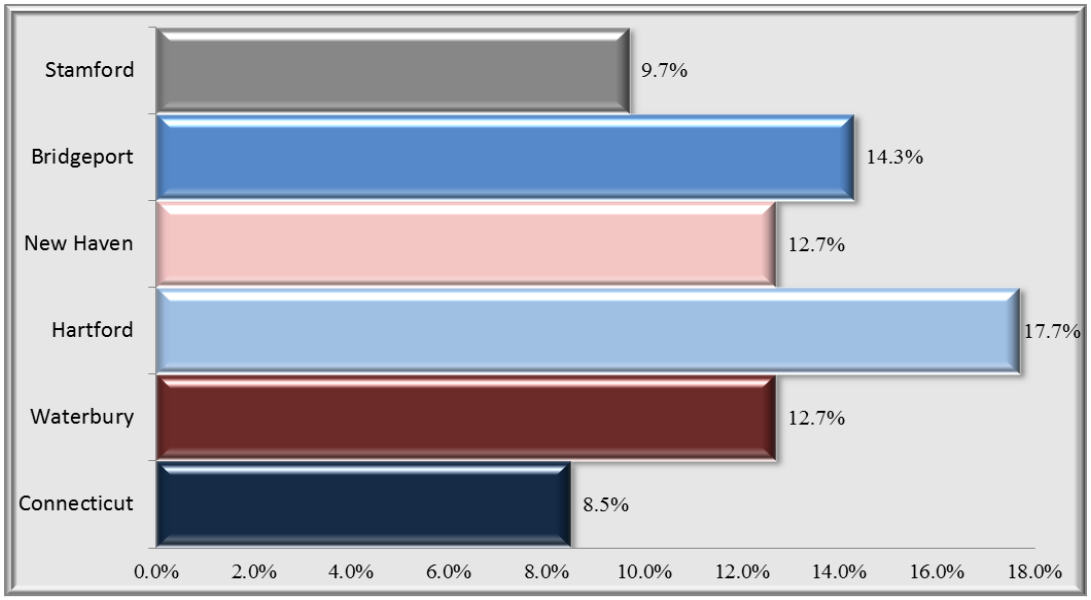



Figure 6. Unemployment rate for civilian labor force, 2009-2011
Source: U.S. Census Bureau, 2012

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).

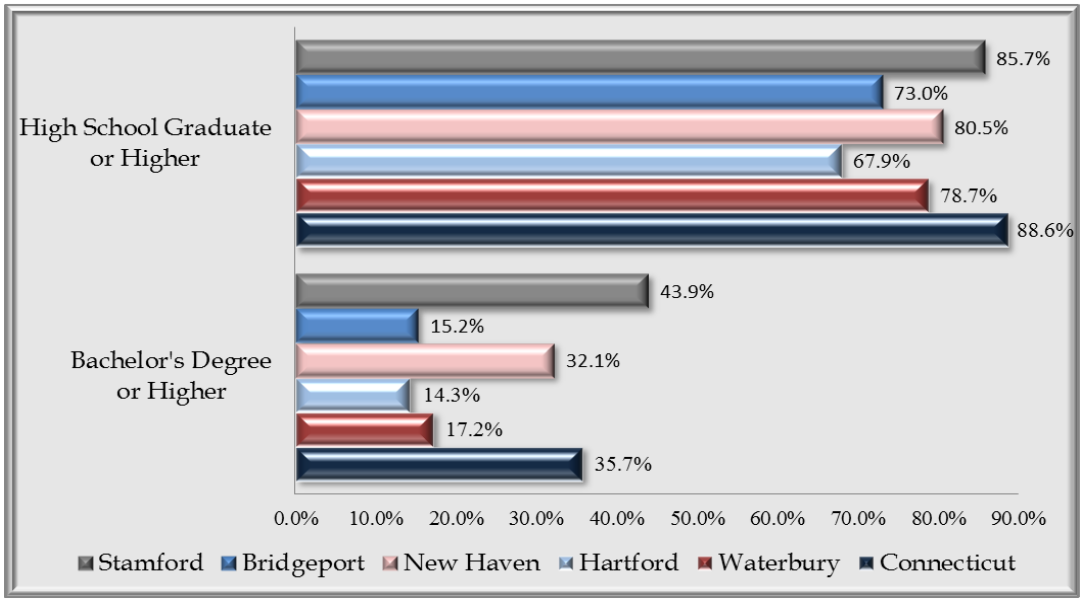



Figure 7. Educational attainment, 2009-2011
Source: U.S. Census Bureau, 2012

## 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).

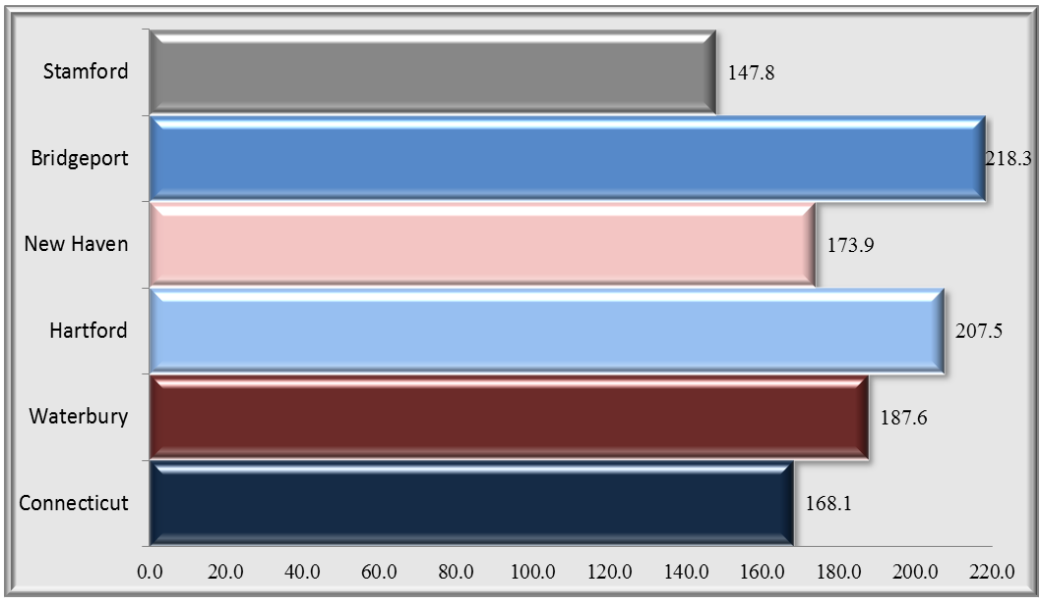



Figure 8. Deaths due to diseases of the heart per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

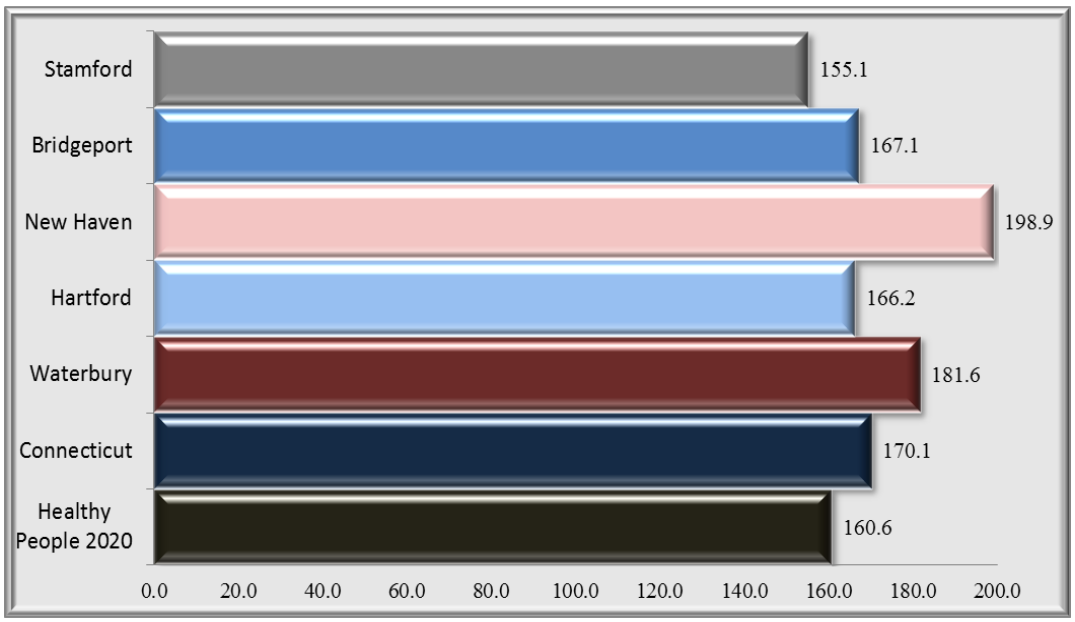



Figure 9. Deaths due to malignant neoplasms (cancer) per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011; Healthy People 2020, 2012;
Connecticut Department of Public Health, n.d.

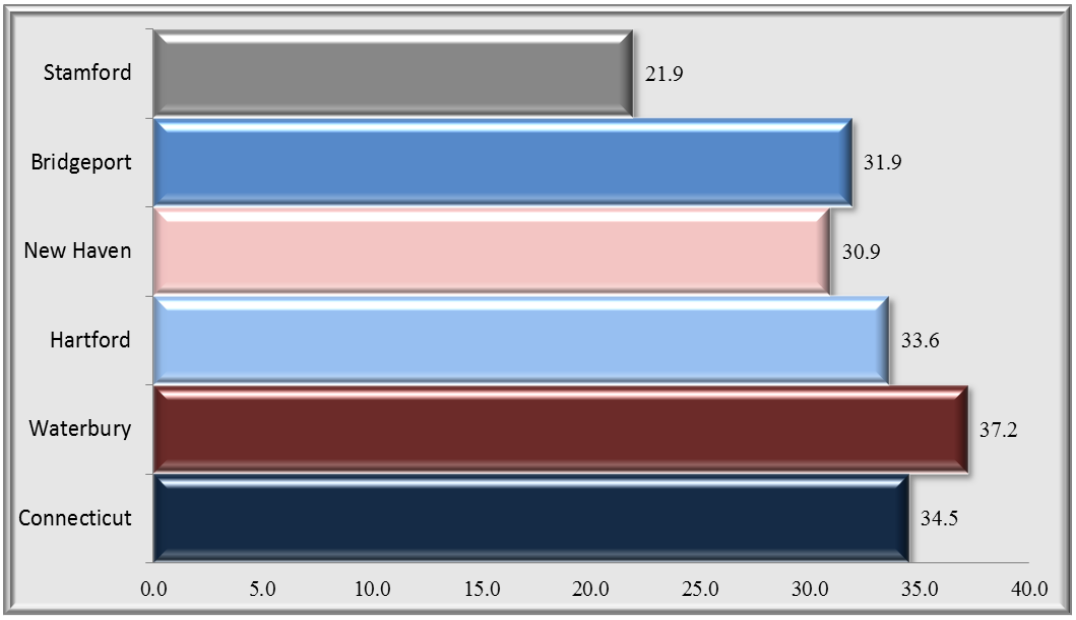



Figure 10. Deaths due to chronic lower respiratory disease per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

**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).

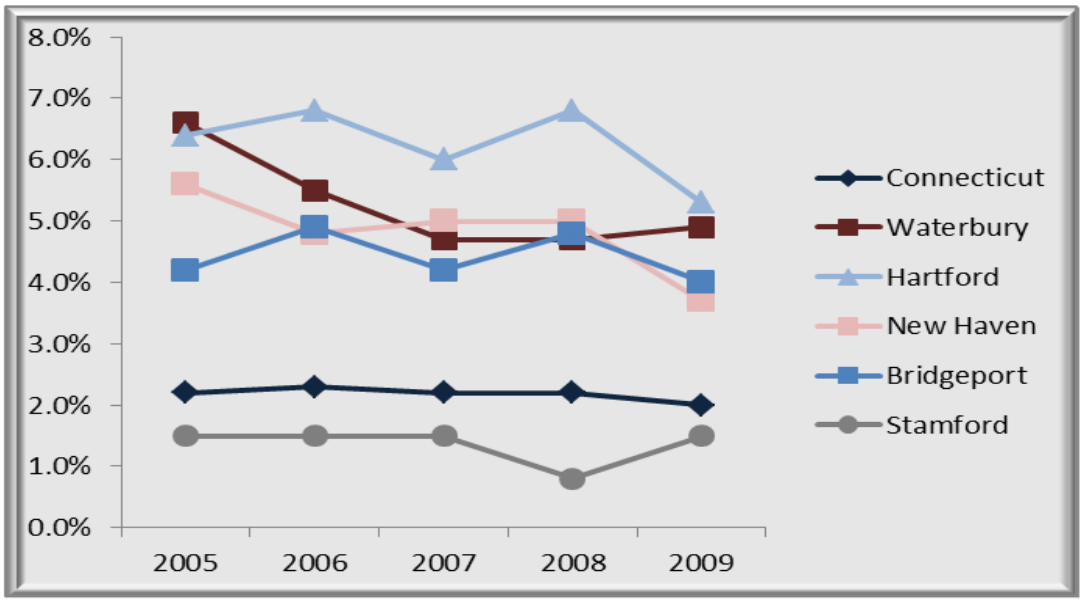



Figure 11. Births to teenagers less than 18 years, 2005 - 2009
Source: Connecticut Department of Public Health, 2007 - 2011

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).

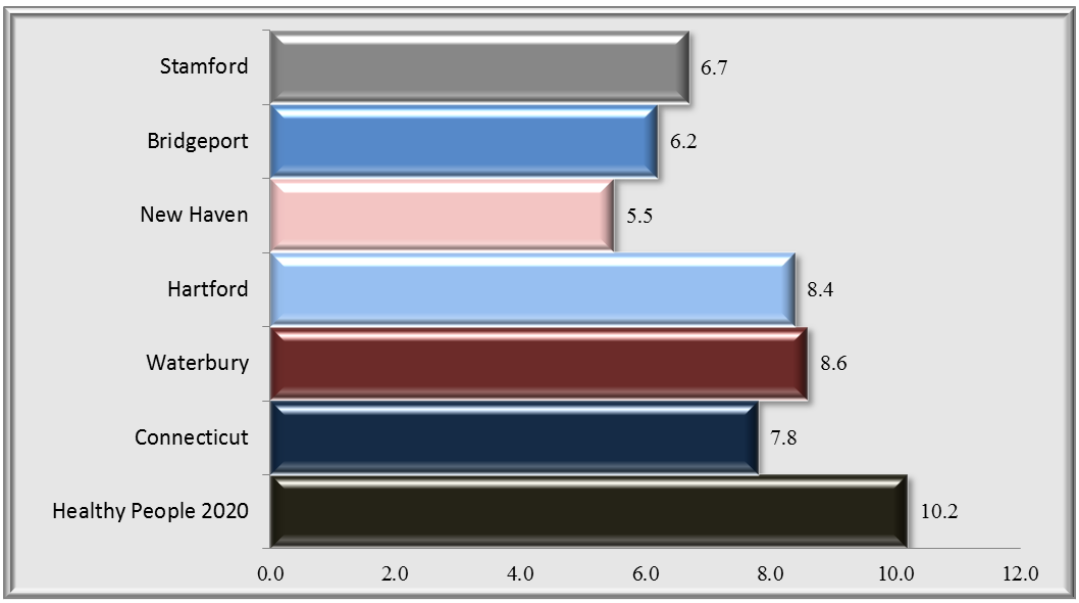



Figure 12. Suicide rates per 100,000, 2005 - 2009
Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

**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.

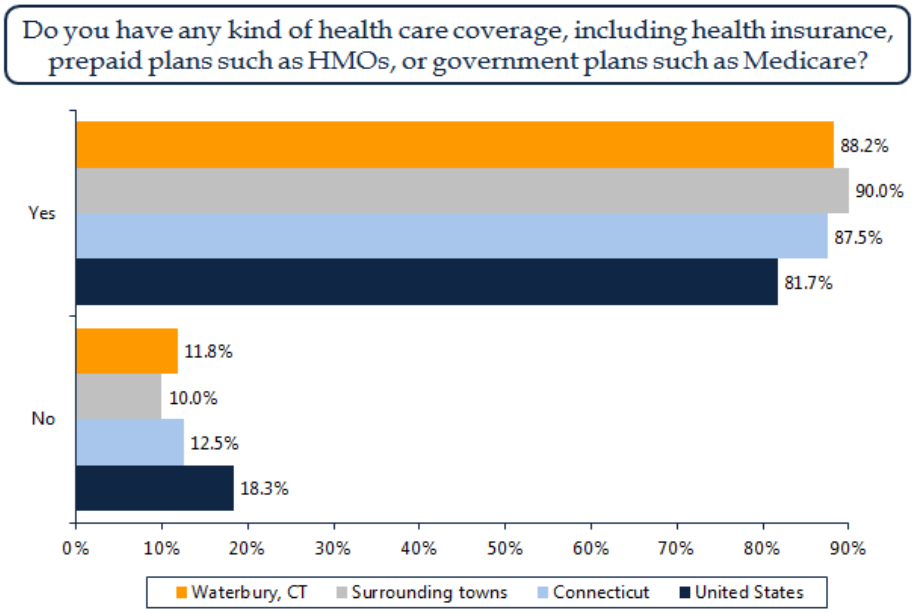
Statistical considerations for the study can be found in Appendix B. The following section provides a summary of the Household Telephone Survey results. A full report of the Household Telephone Survey results is available in a separate document.

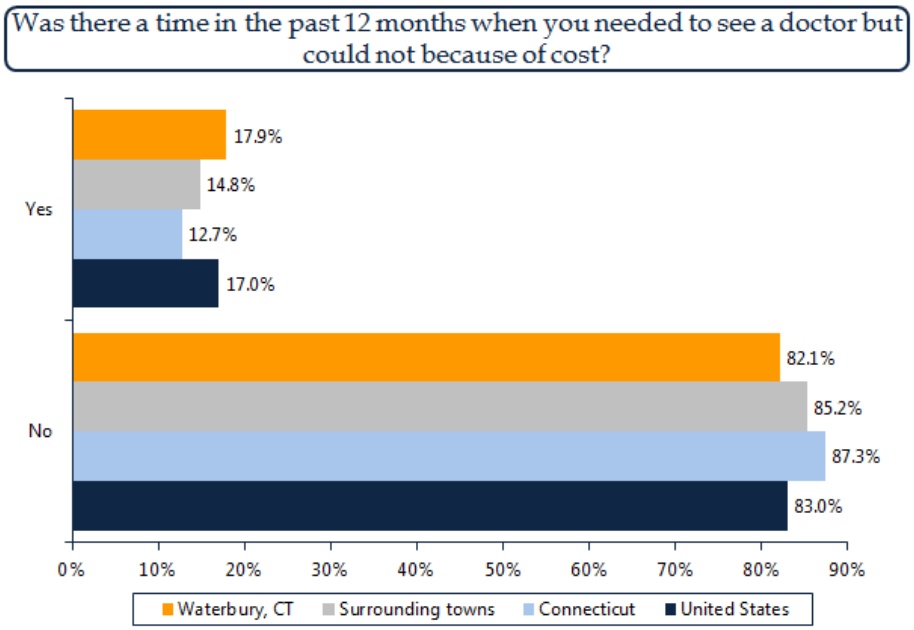
## Household Telephone Survey Key Findings

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.

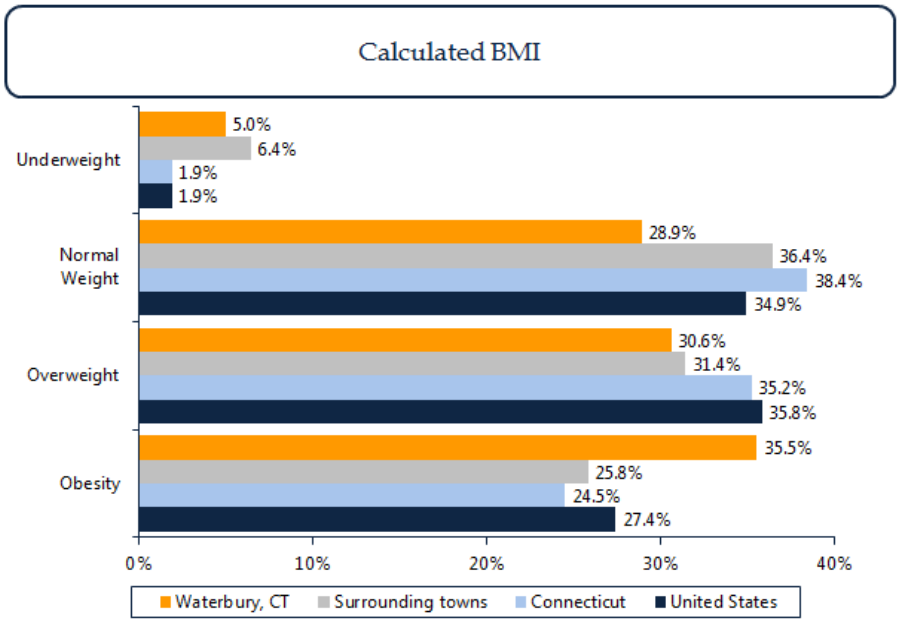



## Health Risk Factors

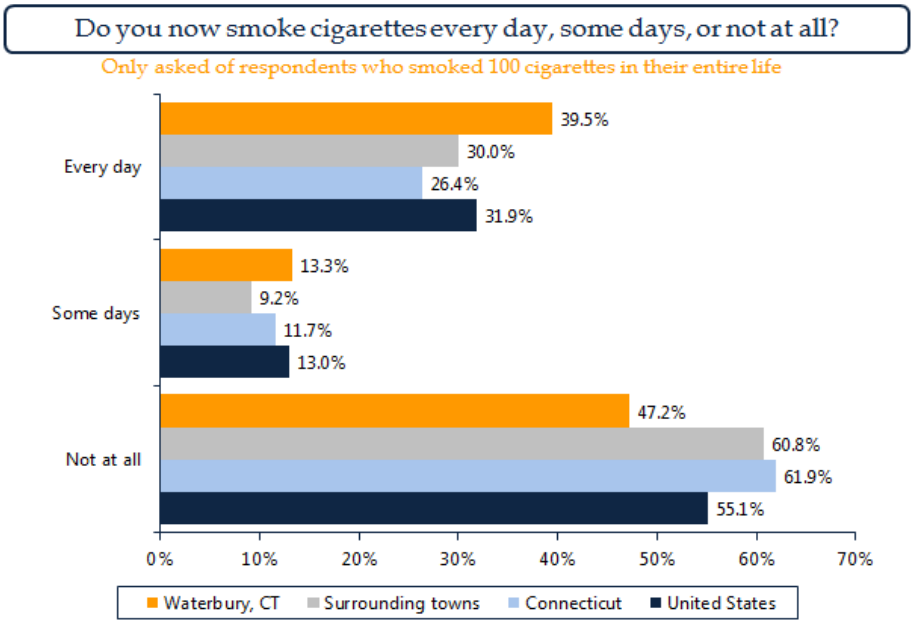
Obesity & Physical Activity

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%).

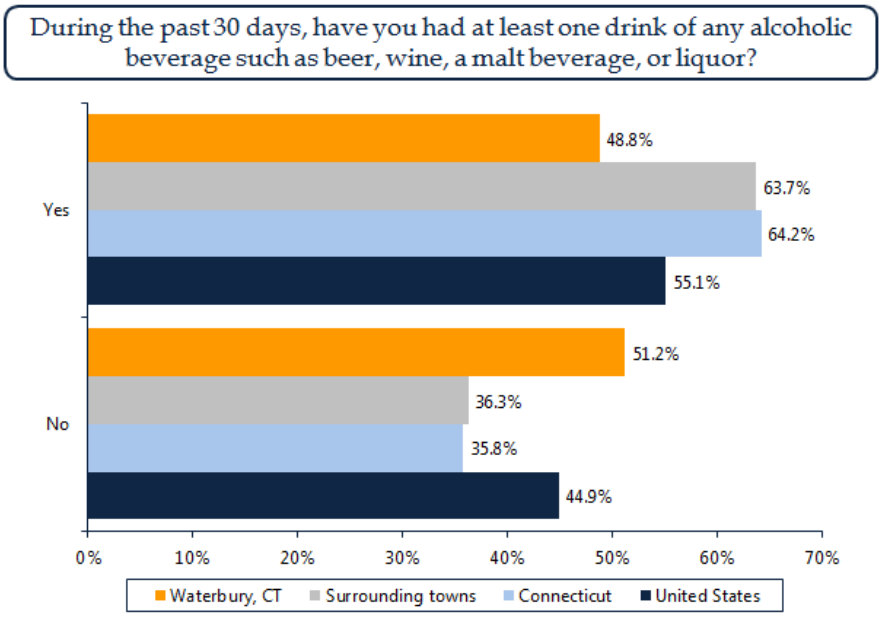



Tobacco & Alcohol Use

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.



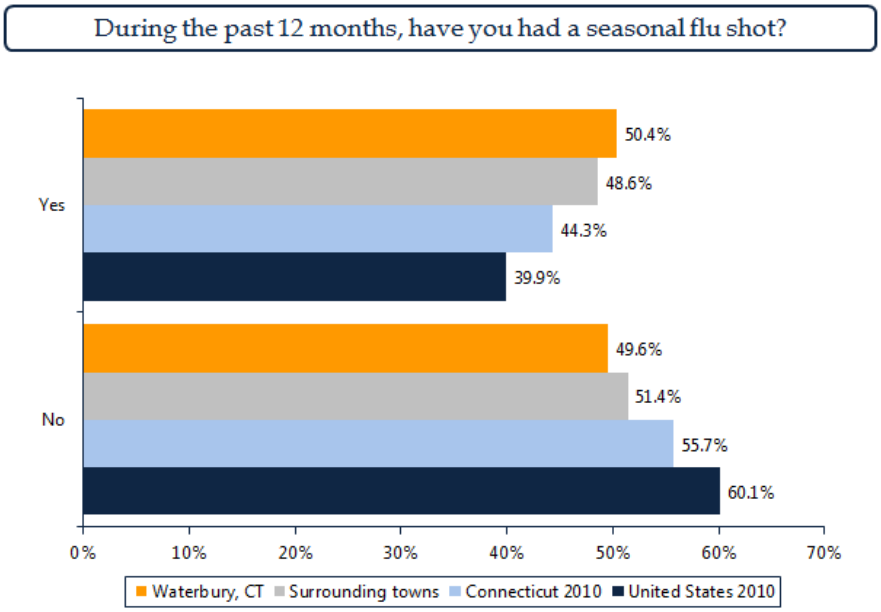
Alcohol use and abuse is not as prevalent. Only 48.8% of respondents had an alcoholic beverage during the past 30 days compared to 64.2% across Connecticut and 55.1% across the nation. Of the individuals who did consume alcohol, fewer did so on a daily basis or participated in binge drinking, and more than half had a maximum of one to two drinks at a time.




## Preventive Health Practices

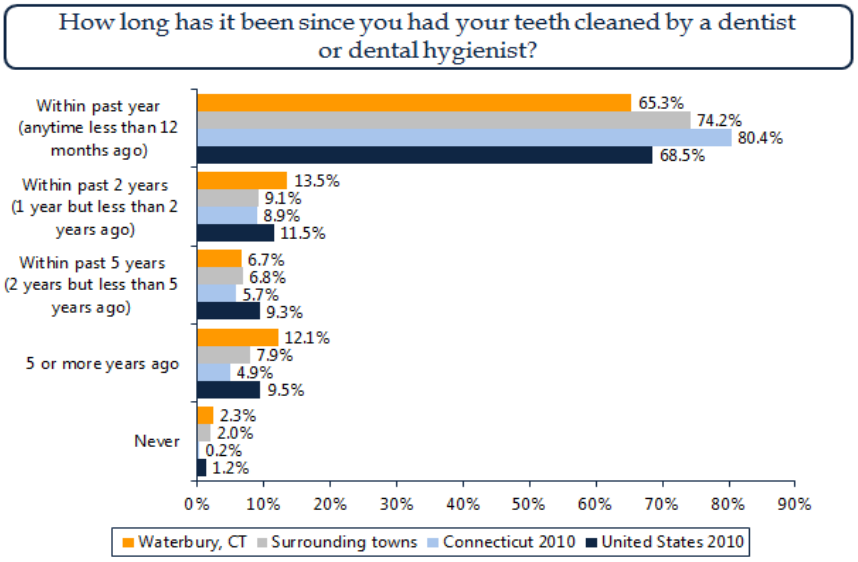
Immunizations

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.

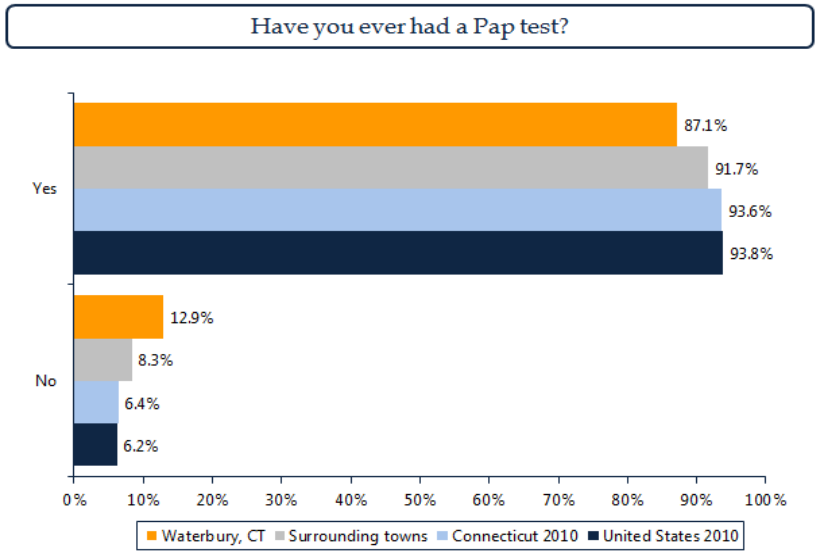


Screenings

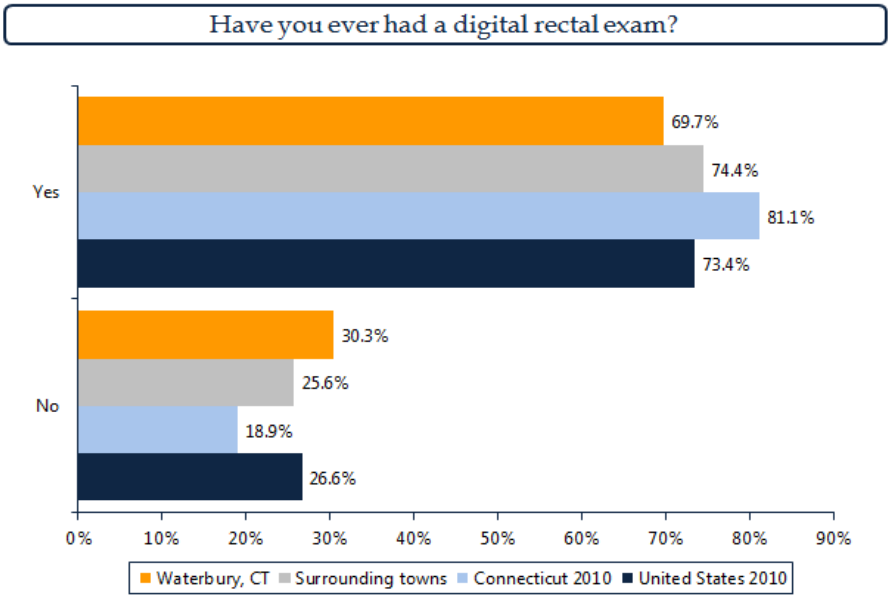
In general, Waterbury residents are less likely to engage in preventative oral health practices. Only 60.8% of respondents visited a dentist or a dental clinic within the past year. This is consistent with the nation (68.1%), but notably lower when compared to Connecticut (80.6%). Waterbury respondents 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%).

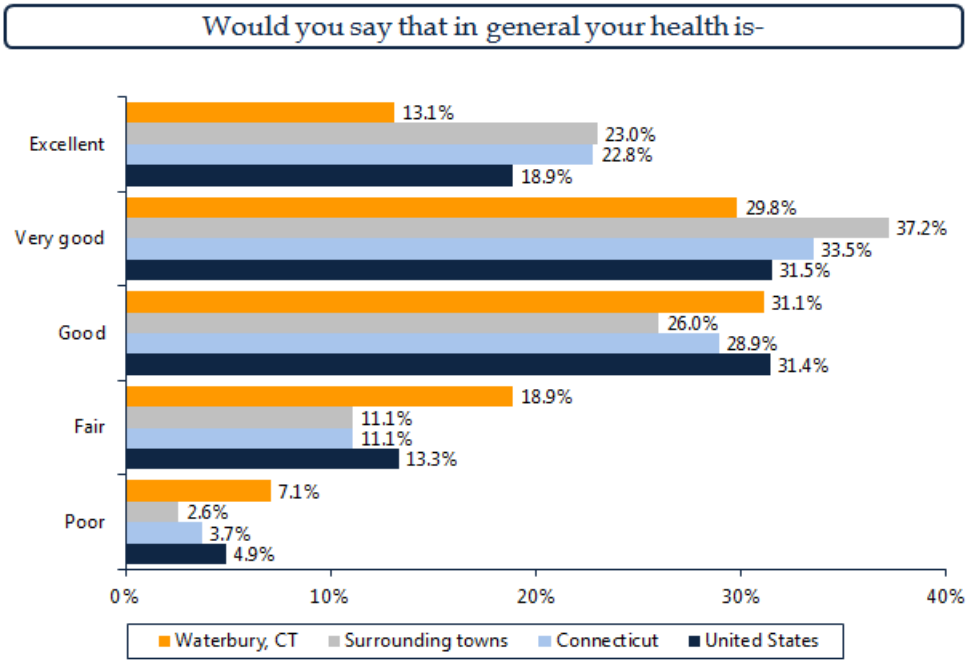
Residents in Waterbury are more likely to have been tested for HIV (55.7%) when compared to residents across Connecticut (36.7%) and the nation (37.4%). By itself, this is a positive finding. However, additional data suggests that a possible reason for higher screening rates is the prevalence of high 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.

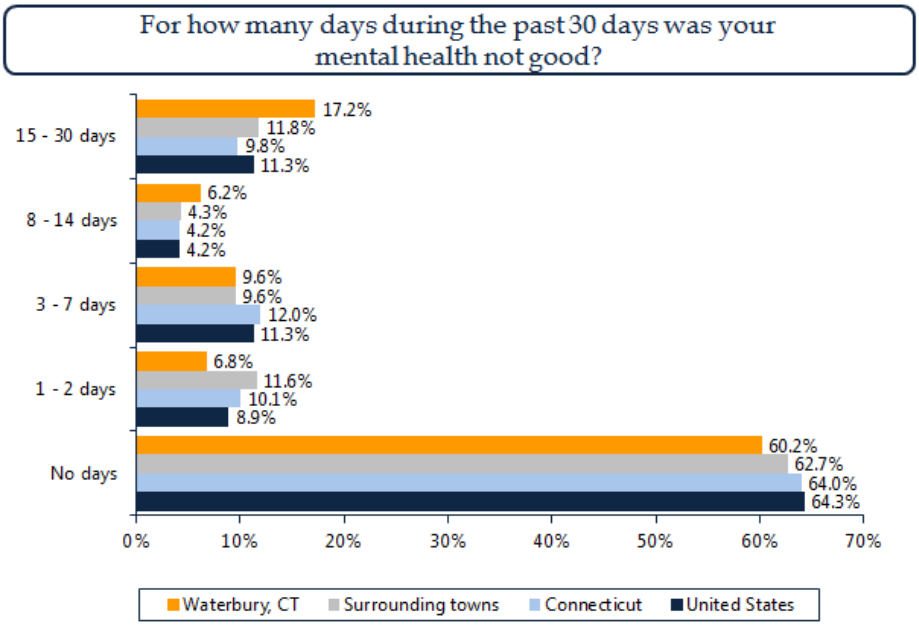
## Health Status & Chronic Health Issues

Physical & Mental Health

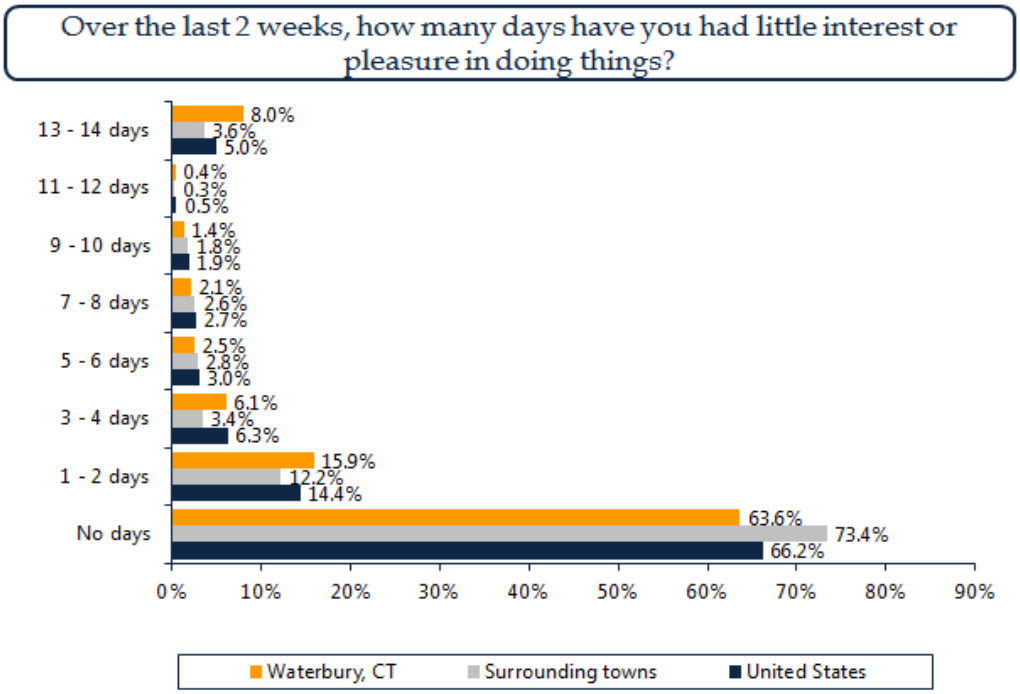
Residents of Waterbury are more likely to report having fair or poor health in general. Only 13.1% of respondents said that their health was excellent, compared to Connecticut (22.8%) and

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.



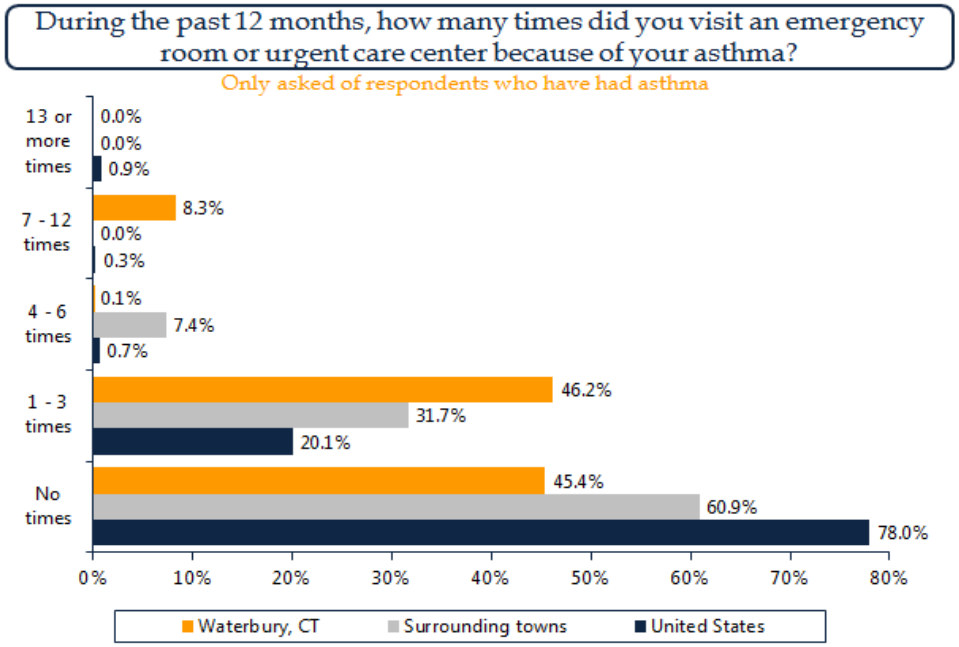
In addition to having more days of poor mental health, Waterbury respondents are more likely to have been diagnosed with an anxiety disorder and to have felt depressed and had little interest in doing things. The percentage of Waterbury respondents who have been diagnosed with an anxiety disorder is 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%).



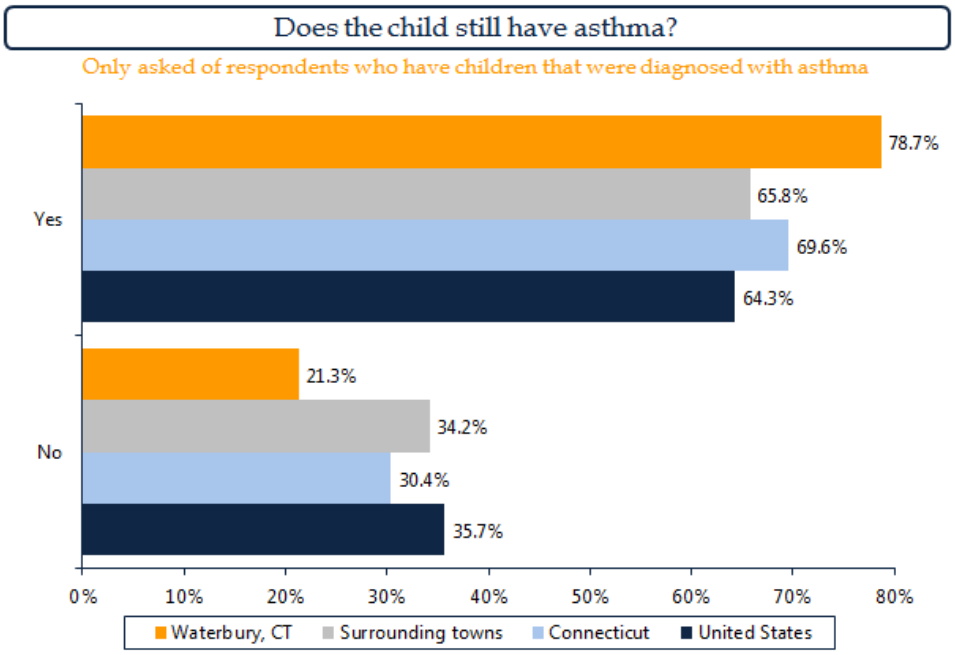

A contributing factor to the poor mental health status of Waterbury residents may be the proportion of residents who are acting as caregivers for friends or family members. During the past month, 27.1% of respondents provided caregiver services compared to 15.6% across Connecticut and 16.8% across the 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%).

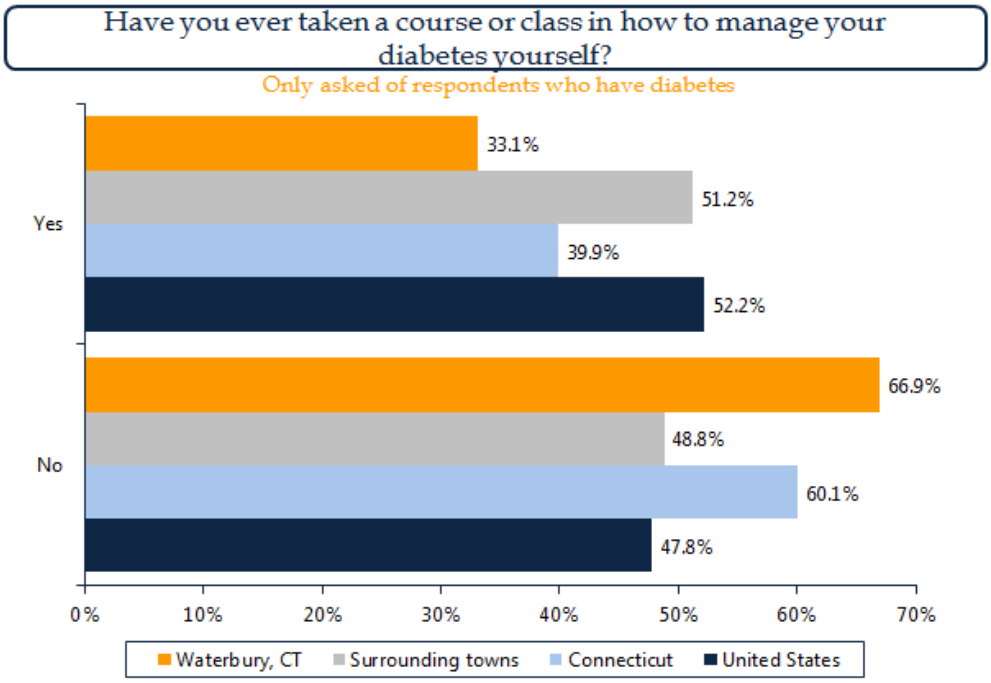



Children in Waterbury are also disproportionately affected by asthma. Slightly more than 21% have been diagnosed with asthma compared to 15.0% in Connecticut and 13.4% in the nation. They are also more likely to still have asthma (78.7%) when compared to Connecticut (69.6%) and the nation (64.3%).



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?"**

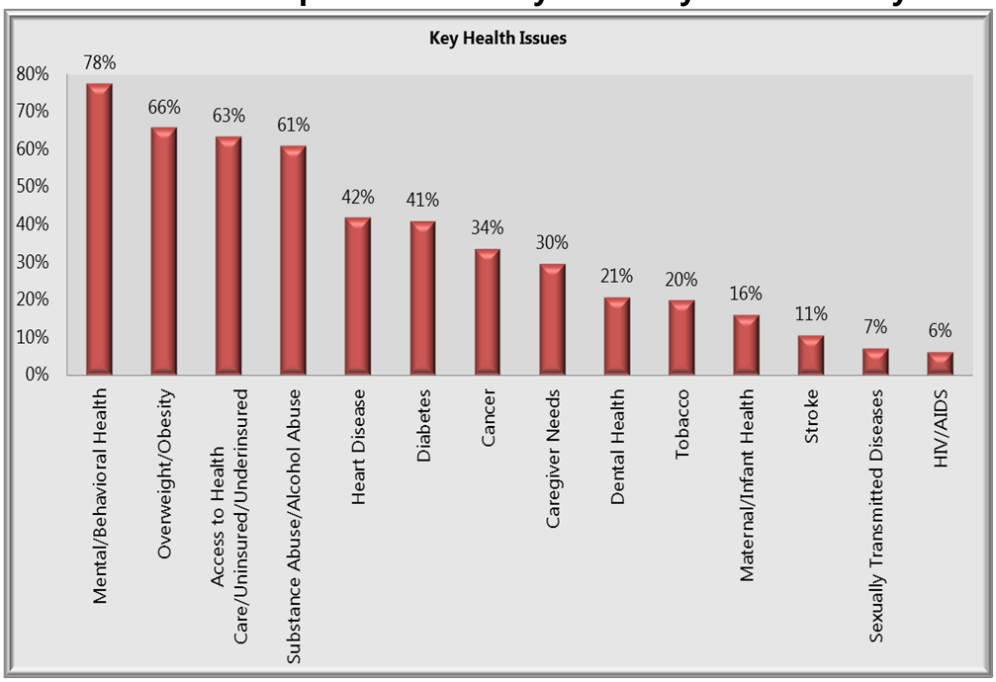



**Figure 1: Ranking of key health issues**

## 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.

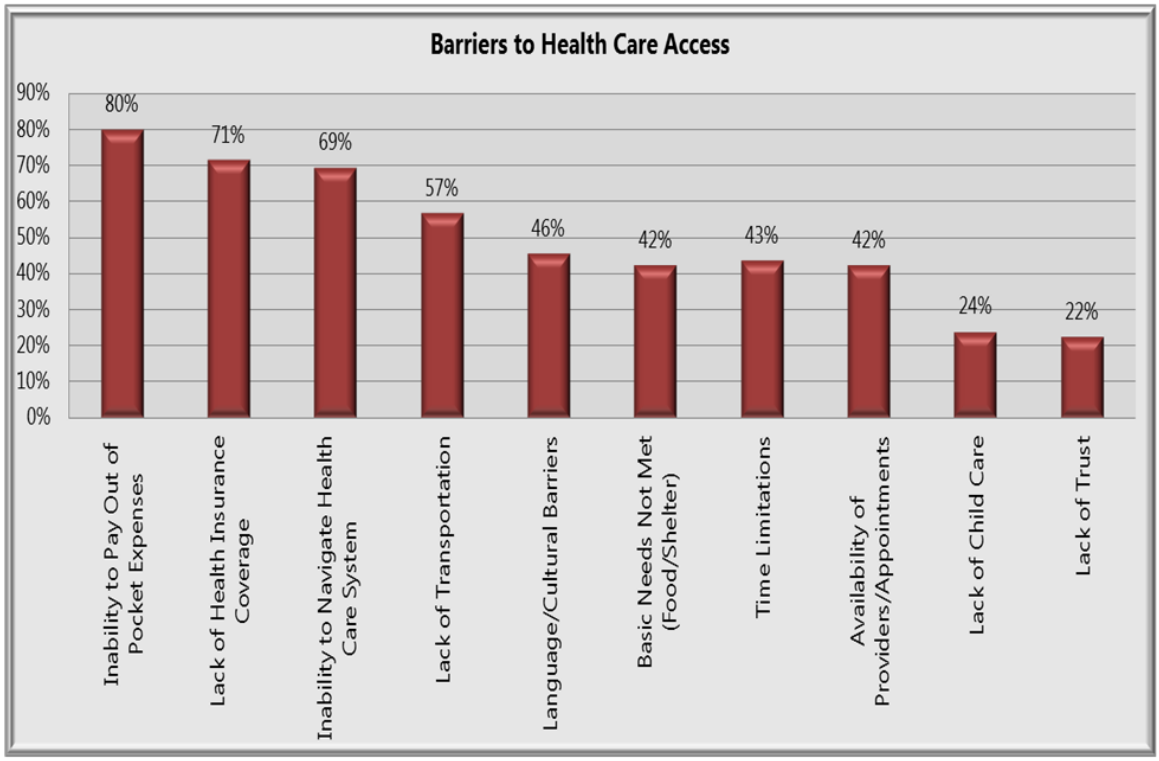



**Figure 2: Ranking of barriers to health care access**

### 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?"**

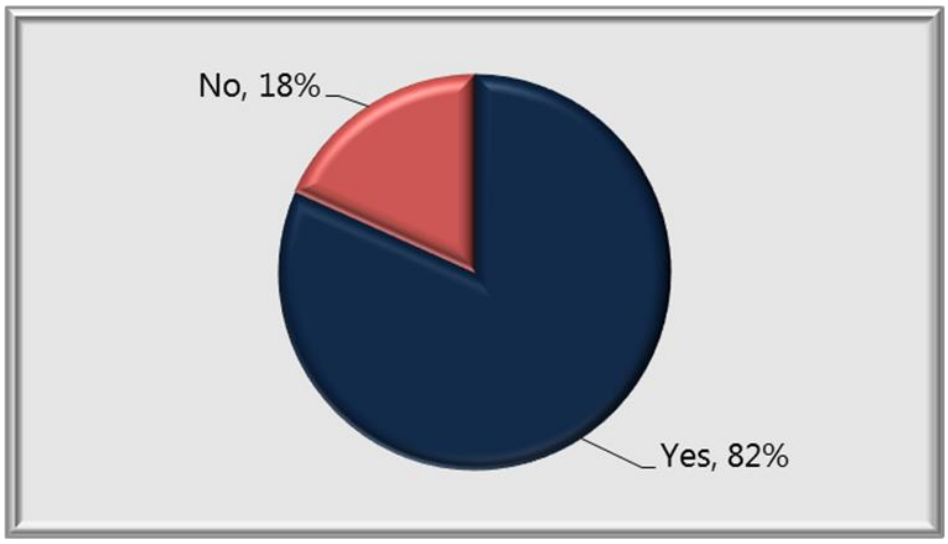



**Figure 3: Key informant opinions regarding underserved populations**

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?**

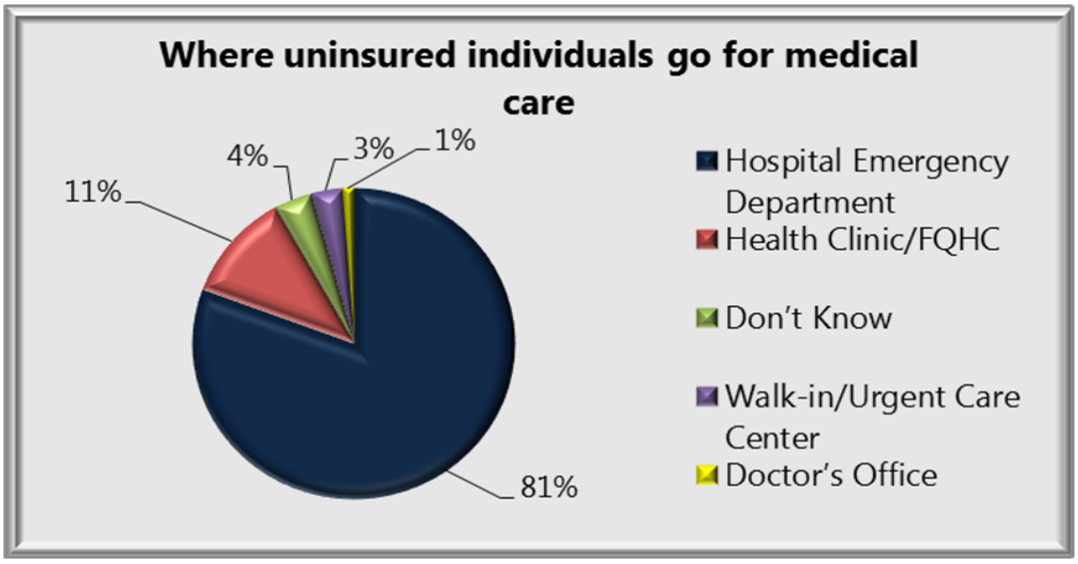



**Figure 4: Key informant opinions of where uninsured individuals receive medical care**

### 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

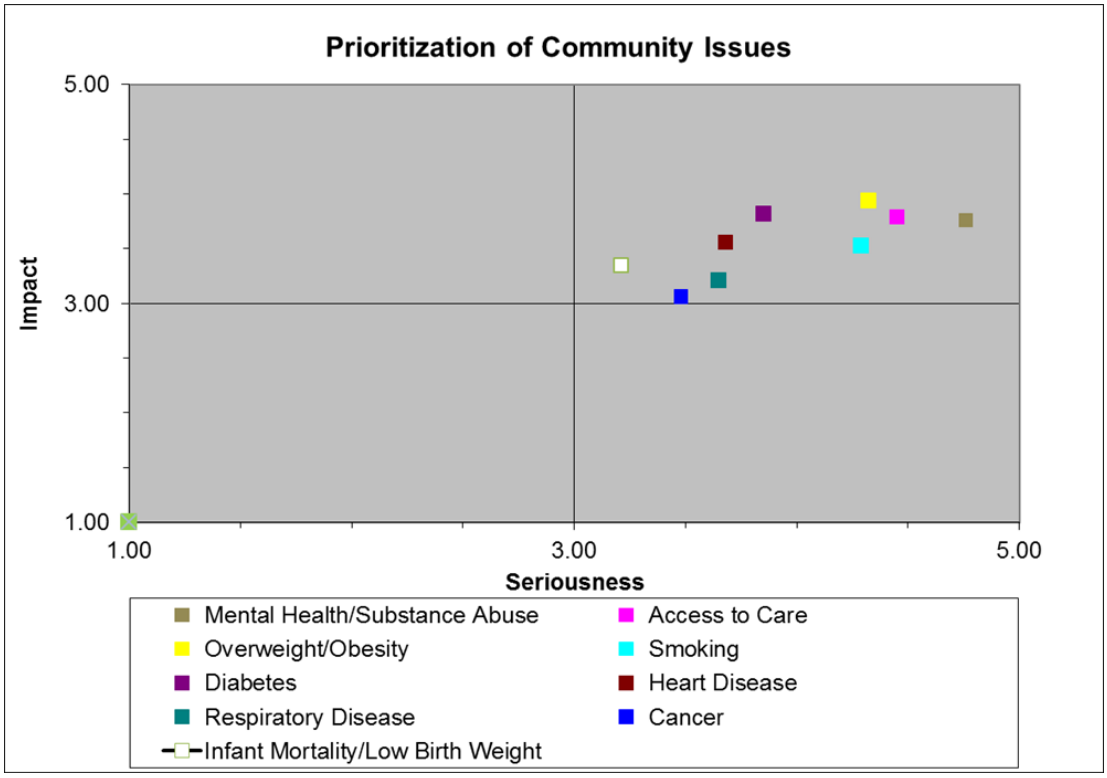
## Key Community Health Issues

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 |

# 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

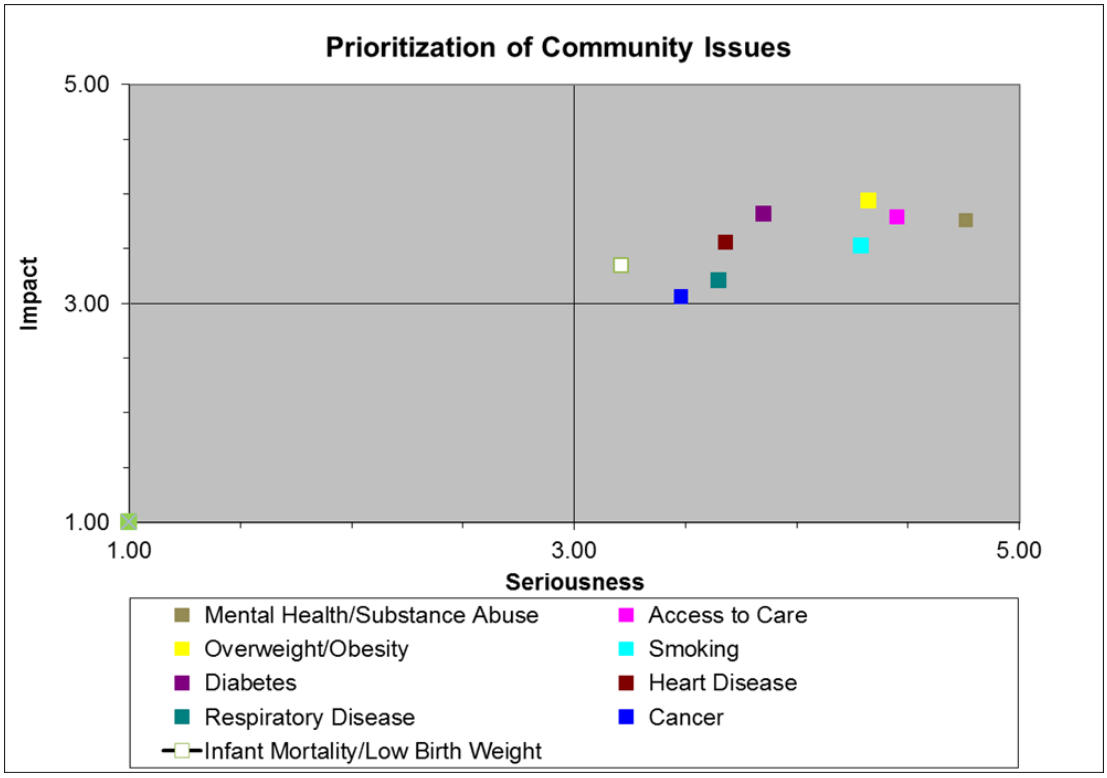
## Key Community Health Issues

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 7

# Saint Francis *Care* ~ Service Lines and Support Platforms

## Service Lines

- Behavioral Health
- Cardiovascular
- Connecticut Joint Replacement Institute
- Emergency Medicine & Pre-Hospital
- Medicine
- Oncology
- Physical Medicine & Rehabilitation
- Primary Care
- Surgery
- Women & Children

## Support Platforms

### Clinical
Care Coord / Case Mgt
Critical Care
Diagnostics
Infection Control
Informatics
Nursing Practice
Pastoral Care
Patient Liaisons
Pharmacy
Quality / Risk Mgt

### Business & Services
Business Development
Compliance
Enterprise Risk Mgt
Finance / Audit
Government Relations
Human Resources
Information Technology
Legal / Regulatory
Marketing / Comm
Mission Integration
Strategic Planning
Supply / Materials Mgt

### Innovation & Learning
Education
Innovation
Leadership Development
Library
Performance Improvement
Research
SFC Solution System
Simulation

### Facilities
Biomedical
Engineering
Food Services
Housekeeping
Laundry
Security
Space Management
Transport



focus on Patient Experience runs through all

# EXHIBIT 8

# SFC Alliance Approach

Clinical Integration

Joint Contracting

**Service Lines**
- Behavioral Health
- Cardiovascular
- CJRI
- Emergency Med & Pre Hospital
- Medicine
- Physical Medicine & Rehab
- Primary Care
- Surgery
- Women and Infants

**Clinical Support Platform**
- Care Coordination / Case Mgt
- Critical Care
- Diagnostics
- Infection Control
- Informatics
- Nursing Practice
- Pastoral Care
- Patient Liaisons
- Pharmacy
- Quality / Risk Mgt

Clinical Affiliation

## Business & Support Platforms

**Business and Services**
- Business Development
- Compliance
- Enterprise Risk Mgt
- Finance / Audit
- Government Relations
- Human Resources
- IT
- Legal / Regulatory
- Marketing / Comm
- Mission Integration
- Strategic Planning
- Supply Chain

**Facilities**
- Biomedical
- Engineering
- Food Services
- Housekeeping
- Laundry
- Security
- Space Management
- Transport

**Innovation + Learning**
- CIPCI
- Education
- Innovation
- Leadership Dev.
- Library
- PI
- Research
- SFC Solution System
- Simulation

Coordinated Support

**Care Coordination**

# EXHIBIT 9

## Saint Francis *Care* Awards and Recognitions

**NCDR ACTION Registry – GWTG Platinum Award** – Saint Francis has received the American College of Cardiology's NCDR ACTION Registry–GWTG Platinum Performance Achievement Award for 2015. Saint Francis *Care* is one of only 319 hospitals nationwide to receive the honor. The award recognizes Saint Francis's commitment and success in implementing a higher standard of care for heart attack patients and signifies that Saint Francis has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology/American Heart Association clinical guidelines and recommendations. (July 2015)

**Most Wired – 2015** – Saint Francis Hospital and Medical Center has been recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2015 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. This is the sixth consecutive year that Saint Francis was named to the *Most Wired* list. (July 2015)

**US News & World Report/Best Hospitals for Common Care** – Saint Francis was recognized as "High Performing" for the treatment of COPD and Knee Replacement. (June 2015)

**Premier Inc., Diversity Award** – Saint Francis *Care* received the *Diversity Award* at Premier's annual Breakthroughs Conference and Exhibition. The *Diversity Award* honors health systems that have established active programs to evaluate and support minority-, women- and veteran-owned enterprises, as well as small businesses, available through the Premier contract portfolio. (June 2015)

**American Heart Association/Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award** – Saint Francis Hospital and Medical Center has received the *Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award* for implementing specific quality improvement measures outlined by the American Heart Association/American College of Cardiology Foundation's secondary prevention guidelines for patients with heart failure. This marks the sixth year that Saint Francis has been recognized with this award. Saint Francis also received the association's *Target: Heart Failure Honor Roll.* This initiative provides hospitals with educational tools, prevention programs and treatment guidelines designed to reduce the risk of heart failure patients ending up back in the hospital. Saint Francis is the only hospital in the state to earn the *Target: Heart Failure Honor Roll* distinction. (June 2015)

**Women's Choice Award –** Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the *Best Hospitals* for Heart Care. The award is based on cardiac and vascular experience and 30-day mortality and readmission rates for heart attacks and heart failure with additional consideration given to patient satisfaction scores. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 2015)

**Associated Builders and Contractors Excellence -** Enterprise Construction Company is the recipient of the *Excellence in Construction Award* for the Comprehensive Women's Health Center. (January 2015)

**Becker's Hospital Review** – Becker's Hospital Review a leading source of information for healthcare professionals, has listed Saint Francis Hospital and Medical Center among the top 100 hospitals in the country with "great women's health programs." Hospitals were selected for the list based on clinical accolades and recognition for women's health excellence from various healthcare groups and agencies. Those agencies include U.S. News & World Report, Healthgrades, CareChex and UNICEF's Baby-Friendly Hospital Initiative. Saint Francis was one of three hospitals in Connecticut named to the list, along with Hartford Hospital and Yale-New Haven Hospital. (December 2014)

**Women's Choice Award –** Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the *Best Hospitals* for Heart Care. The award is based on cardiac and vascular experience and 30-day mortality and readmission rates for heart attacks and heart failure with additional consideration given to patient satisfaction scores. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. ( January 30, 2015)

**Associated Builders and Contractors Excellence -** Enterprise Construction Company is the recipient of the *Excellence in Construction Award* for the Comprehensive Women's Health Center. (January 29, 2015)

**Women's Choice Award** – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the 2015 *Best Hospitals for Patient Safety*. The award is based on consistently low rates of infections and surgical errors, and patient recommendations. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (December 3, 2014)

**The LeapFrog Group "A" Score –**Saint Francis *Care* has again received an "A" rating Hospital Safety Score℠ from the Leapfrog Group, a national hospital quality watchdog organization. The Leapfrog Group has released its fall 2014 Hospital Safety Scores. For the 6th consecutive time Saint Francis has received an "A" rating. Saint Francis is one of only four hospitals in the state to earn the highest rating and the only Connecticut hospital to receive the "A" rating in both the fall and the spring. Six hospitals received "B" ratings; 12 a "C" rating; and three a "D" rating in the recent rankings. Overall, Connecticut ranked 33rd out of 42 states, with just 16% of its 25 rated hospitals receiving an "A" grade. The Hospital Safety Score℠ for 2014 grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. The grades are derived from analysis of publicly available data using 28 evidence-based, national measures of hospital safety. (November 2014)

**CareChex** – Saint Francis Hospital and Medical Center has also been recognized by CareChex®, a division of Comparion Medical Analytics, for national and state medical excellence achievements in numerous categories in its 2015 hospital quality award rankings. Saint Francis was ranked

90th nationwide for overall medical excellence in hospital care among nearly 4,200 hospitals reviewed, and was the only Connecticut hospital to score in the top 100.

The Hospital also ranked nationally among the hospitals reviewed as:

- #5 in coronary bypass surgery (out of 1,196 hospitals scored )
- #8 in joint replacement (out of 3,497 hospitals scored)
- #9 in major orthopedic surgery (out of 3,499 hospitals scored)

In addition, Saint Francis ranked #1 in Connecticut in the following eight clinical and surgical areas:

- Overall Hospital Care – Medical Excellence
- Overall Surgical Care – Medical Excellence
- General Surgery – Medical Excellence
- Joint Replacement – Medical Excellence
- Neurological Surgery – Medical Excellence
- Orthopedic Care – Medical Excellence
- Orthopedic Surgery (Major) – Medical Excellence
- Spinal Surgery – Medical Excellence

(November 2014/For internal non-commercial use only.)

**Healthgrades®** – Saint Francis *Care* has been recognized for clinical excellence in a national report by Healthgrades, a leading provider of information to help consumers make an informed decision about a physician or hospital. Saint Francis has received top national rankings in the most recent *2015 Quality Achievements Report:*

- *Saint Francis Care earned the Distinguished Hospital Award for Clinical Excellence in 2015. (Embargo January 20, 2015)*
- *100 Best Hospitals for Coronary Intervention, 2 years in a row*
- *Coronary Intervention Excellence Award, 2 years in a row*
- *Top 10% in the Nation for Coronary Interventional Procedures*
- *Recipient of the Healthgrades Stroke Care Excellence Award*
- *Top 10% in the Nation for Treatment of Stroke*
- *100 Best Hospitals for Joint Replacement, 3 years in a row*
- *100 Best Hospitals for Orthopedic Surgery, 2 years in a row*
- *Joint Replacement Excellence Award, 3 years in a row*
- *Orthopedic Surgery Excellence Award, 2 years in a row*
- *Top 5% in the Nation for Joint Replacement, 3 years in a row*
- *Top 5% in the Nation for Overall Orthopedic Service, 2 years in a row*

Saint Francis *Care* also earned a 5-star rating from Healthgrades in additional clinical areas for the treatment of: coronary intervention procedures, treatment of heart attack, coronary bypass surgery, treatment of stroke, repair of abdominal aorta, total knee replacement, total hip replacement, and for spinal fusion surgery. (DHACE, January 20, 2015; Specialty Excellence Awards, October 21, 2014)

**Becker's Hospital Review** – Saint Francis Hospital and Medical Center was named on Becker's Hospital Review list of "125 Hospitals with Great Orthopedic Programs." The announcement recognizes orthopedic surgery departments, programs or dedicated centers that have earned special recognition. Saint Francis is one of only two Connecticut hospitals on the list. This is the fifth year Becker's Hospital Review has compiled this list, and the first time it has included 125 hospitals. (September 2014)

**Joint Commission's Gold Seal of Approval/Stroke Center Accreditation** – Saint Francis Hospital and Medical Center has earned *The Joint Commission's Gold Seal of Approval®* for accreditation of its Stroke Center by demonstrating compliance with The Joint Commission's national standards for healthcare quality and safety. The accreditation award recognizes Saint Francis's dedication to continuous compliance with state-of-the-art standards in its primary care stroke center operations. (August 2014)

**U.S. News & World Report** – In a national survey of 4,806 hospitals, Saint Francis Hospital and Medical Center was one of 752 hospitals to achieve at least one "High Performing" rating among 16 medical specialties in the 25th annual U*.S. News & World Report* ranking Best Hospitals in the U.S. Saint Francis was recognized as high performing in 9 specialties: Cardiology and Heart Surgery; Ear, Nose and Throat; Gastroenterology and GI Surgery; Geriatrics; Nephrology; Neurology and Neurosurgery; Orthopedics; Pulmonology; and Urology. (July 2014)

**LifeChoice Donor Services** – Saint Francis Hospital and Medical Center earned a gold award for their work with LifeChoice Donor Services. LifeChoice Donor Services is among a select group of organ procurement organizations (OPOs) nationwide recognized by the U.S. Department of Health and Human Services (HHS) for reaching gold, silver, and bronze levels of achievement for conducting activities that promote enrollment in state organ, tissue and eye donor registries. The hospitals are part of a national hospital campaign, sponsored by HHS's Health Resources and Services Administration (HRSA), which has added 327,659 donor enrollments to state registries nationwide since 2011, exceeding the goal of 300,000. (July 2014)

**American Diabetes Association** – The American Diabetes Association Education Recognition Certificate for a quality diabetes self-management education program was recently awarded to the Center for Diabetes and Metabolic Services at Saint Francis. The designation assures that programs meet the national standards for Diabetes Self-Management Education Programs. (July 2014)

**Most Wired – 2014** – Saint Francis Hospital and Medical Center has been recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2014 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. This is the fifth consecutive year that Saint Francis was named to the *Most Wired* list. (July 2014)

**Healthgrades: Patient Safety & Women's Health Excellence Awards** – **Saint Francis Hospital and Medical Center** received the *2014 Patient Safety Excellence Award™* and the *Women's Health Excellence Award*, from Healthgrades, the leading online resource for comprehensive information about physicians and hospitals. (June 2014)

- *The Patient Safety Excellence Award* distinction places Saint Francis within the top 10% of all hospitals for its excellent performance in safeguarding patients from serious,

potentially preventable complications during their hospital stays. This is the fourth consecutive year that Saint Francis has received this award, and one of only two Connecticut hospitals to earn the distinction this year.

- The *Women's Health Excellence Award* distinguishes Saint Francis as a top-performing hospital in women's health. Saint Francis is one of only 178 recognized nationally for their outcomes for care provided to women for common conditions and procedures treated in the hospital. Saint Francis is on the only hospital in Connecticut to earn this distinction.

**Premier Supply Chain Excellence Award** – Saint Francis Hospital and Medical Center has received *Premier, Inc.'s Supply Chain Excellence Award* for superior supply expense performance. Saint Francis is one of only 35 Premier members to receive the award this year. Premier, a leading healthcare improvement company, unites an alliance of approximately 3,000 U.S. hospitals and 110,000 other providers. (Embargo Date: June 11, 2014)

**American Heart Association/Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award** – Saint Francis has received the *Get With The Guidelines®–Heart Failure Gold-Plus Quality Achievement Award* for implementing specific quality improvement measures outlined by the American Heart Association/American College of Cardiology Foundation secondary prevention guidelines for heart failure patients. This marks the third time that Saint Francis has been recognized with a quality achievement award. (May 2014)

**The LeapFrog Group "A" Score** – Saint Francis Hospital and Medical Center has again received an "A" rating Hospital Safety Score℠ from The Leapfrog Group, a national hospital quality watchdog organization. This is the 5th consecutive "A" rating received by Saint Francis from The Leapfrog Group. Saint Francis was one of two hospitals in the state to receive an "A" grade from Leapfrog in the latest rating for spring 2014, and the only hospital to receive the "A" rating in both the fall and spring. Among the 25 Connecticut hospitals, 8 received a "B," 13 received a "C," one received a "D," and one received an "F." Scores went down for four hospitals, while three hospitals improved their scores. (April 2014)

**Women's Choice Award** – Saint Francis Hospital and Medical Center has received the Women's Choice Award from WomenCertified®, distinguishing it as one of the 2014 Best Hospitals for Patient Experience in Heart Care. The award is based on robust criteria that include female patient satisfaction measurements as well as clinical excellence considerations. WomenCertified® represents the collective voice of female consumers and is a trusted referral source for top businesses and brands identified as meeting the needs and preferences of women. (January 2014)

**Becker's Hospital Review** – Saint Francis Hospital and Medical Center was named on Becker's Hospital Review list of "100 Hospitals with Great Orthopedic Programs." The announcement recognizes orthopedic surgery departments, programs or dedicated centers that have earned special recognition. Saint Francis is the only Connecticut hospital on the list. (January 2014)

**Becker's Hospital Review**– Saint Francis Hospital and Medical Center was named on the Becker's Hospital Review list of *100 Hospitals with Great Heart Program*. Becker's rates hospitals based on recognition for quality care, clinical awards and research contributions to cardiovascular care. (December 2013)

**Alliance of Independent Academic Medical Centers (AIAMC)** – Saint Francis *Care* received the *2014 Innovation Award* from the Alliance of Independent Academic Medical Centers (AIAMC) in recognition of the innovative medical education programs for residents, physicians and staff that have resulted in better patient outcomes. This is the second time the Hospital received the Innovation Award. (December 2013)

**Association of American Medical Colleges** – The Innovation + Learning Center at Saint Francis was one of national 13 recipients to receive the *Association of American Medical Colleges Learning Health System Challenge and Planning Award*, which recognizes innovations in medical education, care delivery, research, and diversity and inclusion. At Saint Francis, the award was given for emphasis on studying efforts to improve everyday clinical practice and health equity in an accountable care environment across the system. (December 2013)

**Healthgrades®** – Saint Francis *Care* was recognized for clinical excellence in a new national report by Healthgrades, a leading provider of information to help consumers make an informed decision about a physician or hospital. Saint Francis has received top national rankings in the most recent *American Hospital Quality Outcomes 2014: Healthgrades Report to the Nation*, which evaluates hospital performance at over 4,500 hospitals nationwide for 31 of the most common inpatient procedures and conditions. Saint Francis ranks among the top 5% nationally in Coronary Interventional Procedures, Overall Orthopedic Services, and, for the second year in a row, Joint Replacement; and the top 10% for Spine Surgery. (October 2013)

**The LeapFrog Group "A" Score** – Saint Francis Hospital and Medical Center has received an "A" rating Hospital Safety Score℠ from The Leapfrog Group, a national hospital quality watchdog organization. The Hospital Safety Score℠ for fall 2013 grades hospitals on their overall performance in keeping patients safe from harm and preventable errors. This is the fourth consecutive "A" rating received by Saint Francis from The Leapfrog Group. The grades are derived from expert analysis of publicly available data using 28 evidence-based, national measures of hospital safety. Saint Francis was one of three hospitals in the state to receive an "A" grade from Leapfrog in the rating for fall 2013, and one of only two to receive the honor twice this year. Among Connecticut hospitals, 7 received a "B," 15 received a "C," one received a "D," and one received an "F." (October 2013)

**Daily Point of Light Award** – Points of Light, the world's largest volunteer organization, named Michael R. Bourque, M.D., a senior OB/GYN physician at Saint Francis Hospital and Medical Center, a *Daily Point of Light Award* honoree for his leadership role on the "Blue Team," a medical missionary team with International Medical Missions of Saint Francis Hospital and Medical Center. Dr. Bourque is the recipient of this prestigious award honoring his commitment to bringing first-class medical services to those in need. (October 2013)

**CareChex®** – Saint Francis Hospital and Medical Center was recognized by CareChex®, a division of Comparion Medical Analytics, for patient safety and medical excellence achievements in numerous categories in its 2014 hospital quality award rankings. Saint Francis ranked #1 in Connecticut in 24 clinical and surgical areas for patient safety and medical excellence. In the area of Patient Safety: Overall Hospital Care, Overall Surgical Care, Cardiac Care, Coronary Bypass Surgery, Gastrointestinal Care, Gastrointestinal Hemorrhage, Interventional Coronary, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, and Major Orthopedic

Surgery. For Medical Excellence: Overall Hospital Care, Overall Surgical Care, Coronary Bypass Surgery, Gastrointestinal Care, General Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, Orthopedic Care, Major Orthopedic Surgery, Spinal Fusion, and Spinal Surgery. (October 2013)

**IBCLC Care Award** – Saint Francis Hospital and Medical Center received *IBCLC Care Award* from the International Board of Lactation Consultant Examiners® (IBLCE®) and International Lactation Consultant Association® (ILCA®) for excellence in lactation care. The recognition is given to facilities that: have a lactation program that is available 5-7 days a week; provided recent breastfeeding training for medical staff; and have recently completed activities that help protect, promote, and support breastfeeding. (August 2013)

**American Heart Association/American Stroke Association *Get With the Guidelines Gold Plus Award*** – Saint Francis Hospital and Medical Center received the *Get With The Guidelines®–Heart Failure Gold Plus Quality Achievement Award* from the American Heart Association. The recognition signifies that Saint Francis has reached an exceptional goal of treating heart failure patients according to the guidelines of care recommended by the American Heart Association/American College of Cardiology. This marked the second consecutive year that Saint Francis has been recognized with the *Gold Plus* quality achievement award. Saint Francis was one of just three hospitals in Connecticut to receive *Gold Plus* recognition that year. (August 2013)

**Consumer Reports** – *"Best Hospital for Surgery"* – Saint Francis Hospital and Medical Center was one of two statewide hospitals to receive the highest ranking available by Consumer Reports Health Ratings Center in their *"Best Hospitals for Surgery"* Ratings report appearing in the September 2013 issue of Consumer Reports magazine. Of the almost 2,500 hospitals rated by Consumer Reports in all 50 states plus Washington, D.C. and Puerto Rico, Saint Francis Hospital and Medical Center received not only the highest overall surgery Rating in state rankings, it was also named among the top five U.S. hospitals that perform the safest knee and hip replacement surgeries, and the only hospital rated in these two categories in the state. (July 2013)

**Most Wired – 2013** – Saint Francis Hospital and Medical Center was recognized as one of the nation's *Most Wired* hospitals, according to the results of the 2013 *Most Wired* Survey published in the July issue of Hospitals & Health Networks magazine. Named to the *Most Wired* list for the fourth consecutive year, Saint Francis is one of only eight hospitals in Connecticut to be recognized on the *Most Wired* list that year. (July 2013)

**U.S. News & World Report – Best Hospitals** – Saint Francis Hospital and Medical Center ranked #3 in the state of Connecticut and #2 in the Hartford metro area, gaining high scores in eight specialties and in patient safety, in the *U.S. News & World Report* ranking of Best Hospitals in the U.S. Top performing specialties at Saint Francis listed in the *U. S. News & World Report* annual rankings of Best Hospitals include Cardiology and Heart Surgery, Diabetes and Endocrinology; Gastroenterology and GI Surgery, Geriatrics, Nephrology, Orthopedics, Pulmonology and Urology. (July 2013)

**The LeapFrog Group "A" Score** – For the third consecutive year, Saint Francis Hospital and Medical Center was again honored with an "A" Hospital Safety Score by The Leapfrog Group, an independent national nonprofit run by employers and other large purchasers of health benefits.

The A score was awarded in the latest update to the Hospital Safety Score℠. The A, B, C, D or F scores are assigned to U.S. hospitals based on preventable medical errors, injuries accidents, and infections. The Hospital Safety Score was compiled under the guidance of experts on patient safety and is designed to give the public information they can use to protect themselves and their families. (May 2013)

***HealthGrades® Patient Safety Excellence Award™*** – Saint Francis Hospital and Medical Center received the *Healthgrades 2013 Patient Safety Excellence Award™*, according to Healthgrades, the leading online resource that helps consumers search, evaluate, compare and connect with physicians and hospitals. The distinction placed Saint Francis within the top 5% of all hospitals for its excellent performance in safeguarding patients from serious, potentially preventable complications during their hospital stays. This was the third consecutive year that Saint Francis received this prestigious award. Saint Francis was the only hospital in Connecticut to achieve this distinction in 2013. (April 2013)

***Practice Greenhealth/Partner for Change Award*** – for leadership in prioritizing our environmental performance and demonstrating our commitment to a higher standard of excellence in sustainability. This is the fifth time Saint Francis earned this distinction. (April 2013)

***CareChex –*** According to a 2011 CareChex national hospital quality study, Saint Francis Hospital and Medical Center was #1 in the State in the category of "Medical Excellence" for: Major Cardiac Surgery, Coronary Bypass Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Orthopedic Care, Major Orthopedic Surgery, Spinal Surgery, and Trauma Care. Additionally, Saint Francis was #1 in the State for Patient Safety in the areas of: Overall Hospital Care, Overall Surgical Care, Cardiac Care, Major Cardiac Surgery, Coronary Bypass Surgery, Interventional Coronary Care, Joint Replacement, Major Bowel Procedures, Major Neuro-Surgery, Major Orthopedic Surgery, Stroke Care, and Trauma Care. (January 2013)

***The LeapFrog Group "A" Score*** – *Saint Francis Hospital and Medical Center* was honored with a second consecutive "A" Hospital Safety Score℠ by The Leapfrog Group, a nationally recognized organization founded by a consortium of Fortune 500 companies and other large public healthcare purchasers representing 37 million American consumers nationwide. Saint Francis was the largest hospital in Connecticut to merit this distinction, and one of only six statewide to receive this recognition. The Hospital Safety Score℠ was calculated under the guidance of The Leapfrog Group's Blue Ribbon Expert Panel using publicly available data on patient injuries, medical and medication errors, and infections. U.S. hospitals were assigned an A, B, C, D, or F for their safety records. (November 2012)

***Connecticut Breastfeeding Coalition*** – Saint Francis Hospital and Medical Center received an award of recognition from the Connecticut Breastfeeding Coalition for its contributions to the health of Connecticut's mothers and children through the Connecticut Breastfeeding Initiative 2010-2012. (October 2012)

***Healthgrades®*** – Saint Francis *Care* was listed as #1 in Connecticut for joint replacement outcomes and is one of America's 100 Best Hospitals for Joint Replacement. Saint Francis *Care* also earned a 5-star rating from Healthgrades in additional clinical areas for the treatment of: heart failure, back and neck surgery, stroke, pneumonia, GI bleed, respiratory failure, diabetic

acidosis and coma. This is according to a report from Healthgrades, *American Hospital Quality Outcomes 2013: Healthgrades Report to the Nation*. Healthgrades is the leading provider of information to help consumers make an informed decision about a physician or a hospital. (October 2012)

**HAVEN Employer Engagement Award** – this award was presented to Saint Francis by the Health Assistance InterVention Education Network (HAVEN). The award recognized employers who, through human resources, employee assistance, and/or occupational health, have developed ways to help employees confront the challenges of physical and mental illness with dignity and compassion. (October 2012)

***"I Am Who I Am"*** – recognized by the Walk In the Light Ministries and by Archbishop Louella Tate as an organization that has helped Hartford become a role model for other cities. (September 2012)

***National Air Filtration Association (NAFA) Clean Air Award*** – recognized for leadership and excellence in the use of high efficiency air filtration products and good maintenance practices. It is presented to those who show an outstanding effort in maintaining a clean and healthy indoor work environment, while reducing overall operating costs. (September 2012)

***Most Wired* – 2012** – recognized by *Hospitals & Health Networks Magazine* for making progress toward adoption of Information Technology. (July 2012)

***Connecticut Quality Improvement Award Gold Prize*** – given to Saint Francis Hospital by the Connecticut Quality Improvement Association for our work in improving the Universal Protocol in our operating room, using the Safe Surgery Checklist. (June 2012)

***The LeapFrog Group "A" Score*** –Saint Francis Hospital and Medical Center was only one of four hospitals in the state to receive an "A" grade on the organization's Hospital Safety Score. The Hospital Safety Score℠ was calculated under the guidance of The Leapfrog Group's Blue Ribbon Expert Panel using publicly available data on patient injuries, medical and medication errors, and infections. U.S. hospitals were assigned an A, B, C, D, or F for their safety. (June 2012)

***HealthGrades® Patient Safety Excellence Award™*** – for patient safety indicators from the Agency for Healthcare Research and Quality (AHRQ) to identify patient safety incidence rates, placing Saint Francis in the top 5% in the nation for patient safety, and the only Connecticut hospital to achieve this distinction. (May 2012)

**American Heart Association/American Stroke Association *Get With the Guidelines Gold Plus Award*** – to the Hoffman Heart and Vascular Institute for providing excellent care to heart failure patients. Saint Francis was one of only three hospitals statewide to receive this award. (May 2012)

***Silver Healthy Hospital Award*, Stryker** – for outstanding performance in reducing environmental harm and improving overall hospital quality through medical device remanufacturing and reprocessing. For 2011, Saint Francis saved $235,600 and had a total waste avoidance of 11,900 pounds. (April 2012)

***Outcome Excellence Award*** – the outpatient rehabilitation staff at 95 Woodland Street received this award from Focus on Therapeutic Outcomes (FOTO) for exceeding the predicted national target for outcomes and patient satisfaction over a one-year period. The targets were met for two consecutive years, for both 2010 and 2011. (April 2012)

***2012 Top Performer*** – the inpatient rehabilitation team at Mount Sinai Rehabilitation Hospital received an Outstanding Performance Award from the Uniform Data Systems database for its top ten percent ranking out of 800 programs across the United States. (April 2012)

***The Blue Ribbon Award*** – for the John T. O'Connell Tower presented at the 17th Annual Awards Showcase from the Real Estate Exchange. This is the most significant annual awards event in commercial real estate in Connecticut and a celebration of excellence in the industry. (April 2012)

***The BUILDCT 2012 Award*** – for the John T. O'Connell Tower best new large construction project greater than $10 million from the Association of General Contractors. The award was given to Saint Francis Hospital and Medical Center; TRO/Jung Brannen, the architect and engineer; and Turner Construction Company, the construction manager. (March 2012)

***Connecticut Quality Improvement Award Silver Innovation Prize*** – for the creation of the Connecticut Institute for Primary Care Innovation. (August 2011)

***American Heart Association/American Stroke Association Get With The Guidelines Gold Plus Award*** – for achievement in using evidence-based guidelines in the treatment of stroke patients. (August 2011)

***Most Wired – 2011*** – recognized by *Hospitals & Health Networks Magazine* for making progress toward adoption of Information Technology. (July 2011)

***Community Value Five-Star Hospital*** – recognized by Cleverly & Associates, a healthcare industry intelligence and education consultancy for value provided to the community, based on financial viability, facility reinvestments, low-cost structures, and high-quality patient care. (July 2011)

***Practice Greenhealth Partner for Change with Distinction*** – for outstanding environmental achievement in healthcare. (April 2011)

***HealthGrades® Patient Safety Excellence Award™*** – for patient safety indicators from the Agency for Healthcare Research and Quality (AHRQ) to identify patient safety incidence rates. (March 2011)

***The American Society for Metabolic and Bariatric Surgery and the Surgical Review Corporation Bariatric Surgery Center of Excellence® Designation –*** for demonstrating an unparalleled ability to consistently deliver safe, effective, evidence-based care. (March 2011)

***Focus on Therapeutic Outcomes, Inc. Outcomes Excellence Award*** – for exceeding the national average for functional change in the patients treated at the Center for Rehabilitation and Sports Medicine. (March 2011)

***The American College of Cardiology Foundation NCDR ACTION Registry Gold Performance Award*** – for implementing a higher standard of care and reaching the aggressive goal of treating coronary artery disease patients with 85 percent compliance with American College of Cardiology/American Heart Association clinical guidelines and recommendations. (December 2010)

***The American Alliance of Healthcare Providers Choice Award*** – for implementing an excellent healthcare program that successfully results in courteous, compassionate, and caring service to patients, families, and the community. (July 2010)

***Most Wired "Most Improved" Award*** – for the Hospital's level of achievement in business and administrative management, clinical quality and safety, continuum of care, and infrastructure. Based on a survey by *Hospitals & Health Networks* Magazine, McKesson Corporation and the College of Healthcare Information Management Executives. (July 2010)

***Practice Greenhealth Partner for Change Award*** – for continuously improving and expanding upon mercury elimination, waste reduction and pollution prevention. Presented by Practice Greenhealth, a national membership organization for healthcare facilities committed to environmentally responsible operations. (May 2010)

**Anthem Blue Cross and Blue Shield Blue Distinction Center for Knee and Hip Replacement –** In recognition of clinical excellence in knee and hip replacement surgery. (January 2010)

**American Heart Association/American Stroke Association *Get With The Guidelines Gold Plus Performance Achievement Award*** – In recognition of implementing excellent care for stroke patients, according to evidence-based guidelines. (January 2010)

***U.S. Department of Health and Human Services Silver-2 Medal*** – In recognition of efforts promoting organ donation. (October 2009)

***Employer Support of the Guard and Reserves Program*** – Connecticut Above and Beyond Award for support of Hospital employees who are members of National Guard and Reserves. (July 2009)

***Practice Greenhealth Partner for Change Award*** – for continuously improving and expanding upon mercury elimination, waste reduction and pollution prevention. Presented by Practice Greenhealth, a national membership organization for healthcare facilities committed to environmentally responsible operations. (May 2009)

***ENERGY STAR Label*** – for superior energy efficiency and environmental protection. Awarded by the U.S. Environmental Protection Agency. Saint Francis was previously awarded ENERGY STAR labels in 2003 and 2006. (April 2009)

***Connecticut Breastfeeding Coalition Breastfeeding Friendly Employer Award*** – Given for Saint Francis' efforts in supporting breastfeeding by working mothers. (January 2009)

***American Stroke Association Get with the Guidelines$^{SM}$ Silver Achievement Award*** – Given in recognition of Saint Francis' commitment and success in implementing a higher standard of care for stroke patients. To achieve the GWTG-Stroke Silver Achievement Award, Saint Francis consistently followed the treatment guidelines in the GWTG-Stroke program for 12 months. (December 2008)

***UnitedHealthcare Premium® Specialty Center for Total Joint Replacement –*** Given with the designation of ***One Star*** and ***Higher Efficiency***. The program uses national industry standards, medical specialty society and consensus standards to evaluate specialty center programs focused on total joint replacement for the purpose of advancing safe, timely, effective, efficient, equitable and patient-centered care. (September 2008)

***American Alliance of Healthcare Providers Hospital of the Year*** – Top 10 Finalist in 2008 Hospital of the Year Awards, which recognizes the country's most consumer-friendly hospitals. (August 2008)

***HealthGrades® 2009 Spine Surgery Excellence Award*** – This award places Saint Francis among the top 10 percent of hospitals nationwide for spine surgery. (July 2008)

***2008 Most Wired Survey and Benchmarking Study –*** Most Improved Award for information technology enhancements in the survey conducted by *Hospitals & Health Networks* magazine in conjunction with Accenture, McKesson Corp. and the College of Healthcare Information Management Executives. (July 2008)

***Connecticut Quality Improvement Award Silver Innovation Prizes*** – Three awards for projects that streamlined critical areas of healthcare: the treatment of heart attacks, transferring patients from the Emergency Department to nursing units, and vaccinating staff against season influenza outbreaks. (July 2008)

***American Stroke Association Get With the Guidelines$^{SM}$ – Stroke Bronze Performance Award*** – for Saint Francis' commitment and success in implementing a higher standard of stroke care by ensuring that stroke patients receive treatment according to nationally accepted standards and recommendations. To achieve the GWTG-Stroke Bronze Performance Achievement Award, Saint Francis consistently followed the treatment guidelines in the GWTG-Stroke program for 90 days. (May 2008)

***Practice Greenhealth Partner for Change Award*** – for working to reduce mercury, reduce waste and prevent pollution. Presented by Practice Greenhealth, formerly Hospitals for a Healthy Environment (H2), a source of environmental solutions for the healthcare industry. The award honors organizations creating healthy, healing environments committed to eliminating mercury, reducing pollution and recycling waste. (May 2008)

***2008 Alliance Innovation Award –*** Saint Francis Hospital and Medical Center was named an *Alliance Innovation Award* winner by the Alliance of Independent Academic Medical Centers (AIAMC). The award was presented to Saint Francis for its demonstrated leadership in utilizing graduate medical education as a key driver to improve quality, patient safety, and the cost-effectiveness of care. These creative and innovative approaches to medical education and research have resulted in better patient outcomes. (April 2008)

***American Alliance of Healthcare Providers 'Hospital of Choice' Award for First Quarter of 2008*** – for consumer friendliness and unparalleled commitment to good citizenship and community service, based on a review of public information, Web site, news releases, announcements, phone surveys of Hospital staff and application review. (April 2008)

***Verispan 100 Most Highly Integrated Healthcare Networks Best of the Rest*** – a Tier 2 category rating for integrated healthcare networks based on eight categories: integrated technology, contractual capabilities, outpatient utilization, financial stability, service and access, hospital utilization and physicians. (February 2008)

***United Healthcare Premium Specialty Center*** – for cardiac care, spine and total joint replacement surgery. The designations signify that Saint Francis has met rigorous quality criteria based on nationally recognized medical standards and expert advice. They are based on detailed information about specialized training, practice capabilities and proficiencies submitted by Saint Francis to United Healthcare. (January 2008)

***CQIA Silver Innovation Prize*** – for being early adopters of bar code point of care (BPOC) technology to prevent errors during medication administration. BPOC systems use a bedside computer and a variety of clinical information systems to cross check bar codes that are printed on patient wristbands with those bar codes printed on medications. In addition to new bedside technology, the BPOC involved an extensive process within the Pharmacy Department. All 2,800 inventoried products required bar code recognition by the Hospital's clinical information system. In the first six months after implementation, 75 percent of inpatient areas were using this technology and 350,000 medication doses had been bar coded. The CQIA Silver Innovation Award is the nation's oldest, state-level quality award program. (October 2007)

***U.S. Department of Health and Human Services Medal of Honor*** – for achieving at least a 75 percent organ donation rate among eligible patients. This was the third year in a row that Saint Francis received this award. Saint Francis is the only hospital in Connecticut and Western Massachusetts to receive the medal three years in a row. (October 2007)

***AHA Nova Finalist*** – Hartford Regional Lead Treatment Center and Lead Safe House Program, which are based at Saint Francis Hospital and Medical Center, named one of ten finalists for the American Hospital Association's Nova Award, which recognizes programs that improve community health status and are collaborative in nature. The Hartford Regional Lead Treatment Center serves patients both at Saint Francis and the Connecticut Children's Medical Center. (August 2007)

***Blue Center of Distinction*** – designated a *Blue Center of Distinction for Cardiac Care* by the Blue Cross and Blue Shield Association. The nationwide program recognizes those hospitals that meet stringent quality criteria, as established by expert physician panels and national organizations. *Blue Distinction Centers* are required to provide a full range of cardiac services, including inpatient care, cardiac rehabilitation, angioplasty and cardiac surgery. (June 2007)

***Hospitals for a Healthy Environment*** – received the Partners for Change Award in recognition of achievements in improving environmental performance. Also received the Making Medicine Mercury-Free Award for eliminating the use of mercury in medical devices. Hospitals for a

Healthy Environment (H2E) is an independent, not-for-profit organization founded by the American Hospital Association, the Environmental Protection Agency, Health Care Without Harm and the American Nurses Association. H2E is focused on improving healthcare environmental performance. (May 2007)

***Five-Star Hospital*** – recognized as a Community Value Provider by Cleverly + Associates, a Columbus, Ohio, healthcare financial consulting firm. Based on the Community Value Index™, a proprietary index that offers a measure of the value that a hospital provides to its community based on financial strength and reinvestment, cost of care and pricing. (April 2007)

***The President's Volunteer Service Award*** – for the service of more than 700 individuals who volunteered at the Hospital in 2006, contributing over 67,400 hours of service to Saint Francis. Presented by the President's Council on Service and Civic Participation on behalf of President George W. Bush to recognize the best in the American spirit and encourage Americans to contribute to their communities through volunteer service. (January 2007)

***CareScience Select Practice National Quality Leader*** – for excellence in overall hospital quality and efficiency. The award placed Saint Francis among the top 1 percent of performers across 4,500 acute care hospitals in the United States as identified by CareScience, a hospital consulting firm. It was based on 16 clinical indicators for both quality and efficiency. (November 2006)

***ENERGY STAR Label*** – for prudent energy management strategies and proven technologies. Awarded by the U.S. Environmental Protection Agency and U.S. Department of Energy. Saint Francis was first awarded an ENERGY STAR label in 2003. (November 2006)

***eHealthcare Strategy & Trends Silver Award*** – in the category "Best Rich Media" in the Physician/Clinician-Focused Site class for the Hospital's web site Grand Rounds Online feature. Since their introduction in April, 15 Grand Rounds presentations were made available to physicians online. After viewing a presentation online, physicians are able to obtain Continuing Medical Education credit by successfully completing a short quiz. (November 2006)

***U.S. Department of Health and Human Services Medal of Honor*** – for achieving at least a 75 percent organ donation rate among eligible patients. This was the second year in a row that Saint Francis received this award. In the most recent reporting period, Saint Francis secured permission from family members for 11 organ donations out of 13 potential donors. Saint Francis was just one of two hospitals in Northern Connecticut and Western Massachusetts to receive the medal this year. (October 2006)

***HealthGrades® Orthopedic Surgery Excellence Award*** – for superior clinical outcomes in the ninth annual *Hospital Quality in America* study. This award placed Saint Francis among the top 10 percent of hospitals nationwide for orthopedic care. (October 2006)

***Leapfrog Top 50 Hospitals*** – for meeting the quality and safety standards of the Leapfrog Group, a consortium of Fortune 500 companies and other large public healthcare purchasers representing 37 million American consumers. Saint Francis was the only hospital in Connecticut to achieve this distinction. Leapfrog identifies its "Top Hospitals" based on their implementation of practices with the greatest life-saving potential, including computerized physician order entry

(CPOE), ICU physician staff, evidence-based hospital referral and the Leapfrog Safe Practices Score. (October 2006)

***2006 BEACON Medical Technology Award*** – for the Hospital's significant investment in advanced technology in the acquisition of the CyberKnife® stereotactic radiosurgery system. The award was presented by the Biomedical Engineering Alliance & Consortium (BEACON), a regional trade association for the advancement of new medical technology. It recognizes innovative approaches that help Connecticut establish a leadership position in the field of medical technology. (October 2006)

***Sacred Heart University College of Education and Health Professions 2006 Community Partner Award*** – for collaboration with the College's Nursing Department to develop and implement the R.N. to B.S.N. program offered at Saint Francis Hospital and Medical Center. This was the first year that the award was given to an individual or organization who has demonstrated exceptional collaboration to further the educational goals and mission of the College. Saint Francis was one of two recipients honored that year. (October 2006)

***HealthGrades® Third Annual Patient Safety in American Hospitals Study*** – for best performing hospitals for overall patient safety. Saint Francis was one of 238 hospitals identified as reaching the top 15 percent nationwide for patient safety. This award was presented by HealthGrades, a healthcare ratings company. As a category, Medicare patients at these top 15 percent hospitals experienced patient safety incidents, on average, 43.27 percent less often than patients at the bottom 15 percent of all hospitals. (October 2006)

***CQIA Silver Innovation Prize*** – for a project that optimized care in patients with congestive heart failure (CHF). Taking note of the fact that each year nearly 900 patients are admitted to the Hospital with CHF, the Congestive Heart Failure Service decided to establish Connecticut's first dedicated unit to provide comprehensive care for CHF patients. Outcomes for patients treated on the CHF unit have been demonstrably better than those of other CHF patients. The CQIA Silver Innovation Award is the nation's oldest, state-level quality award program. (July 2006)

***Solucient 100 Top Hospitals® Performance Improvement Leader*** – for improving faster and more consistently than its peer hospitals across the nation. Nine performance measures were examined including risk adjusted mortality and complications, average length of stay, expenses, profitability, cash-to-debt ratio, growth in percent of community served, tangible assets and risk adjusted patient safety index. Saint Francis was recognized as one of the hospitals that achieved the fastest rate of consistent annual clinical and organizational improvement over a five-year period. (April 2005)

***Solucient 100 Top Hospitals®*** – for setting benchmarks for the industry in such areas as quality of care, efficiency, financial performance, growing community service and patient safety. This marked the seventh time that Saint Francis was named to the prestigious list of the nation's Top 100 hospitals. At the time, Saint Francis was the only hospital in Connecticut to be named to the Top 100 list on seven or more occasions. (February 2005)

***Solucient 100 Top Hospitals®*** – for setting performance benchmarks across four critical areas: quality of care, operational efficiency, financial performance and adaptation to the environment. This marked the sixth time that Saint Francis had been named to the prestigious

list. At the time, Saint Francis was the only major teaching hospital to be named to the Top 100 list on six occasions. (May 2004)

***Solucient Performance Improvement Leader*** – for developing consistent and effective organization-wide performance improvement across critical measures at a faster rate than other U.S. hospitals between 1997 and 2001. Those measures include quality of care, operational efficiency and financial performance. Among 123 major teaching hospitals included in the study, Saint Francis' cumulative scored placed it in the 99$^{th}$ percentile. This signifies that Saint Francis' rate of improvement over the five years was higher and more rapid than 98 percent of the other major teaching hospitals studied by Solucient. (March 2004)

# EXHIBIT 10

**RESOLUTIONS TO BE CONSIDERED**
**AT**
**A SPECIAL MEETING OF THE BOARDS OF DIRECTORS**
**OF**
**SAINT MARY'S HEALTH SYSTEM, INC.**
**AND**
**SAINT MARY'S HOSPITAL, INC.**
**TO BE HELD**
**ON**
**THURSDAY, SEPTEMBER 17, 2015**

WHEREAS, Saint Mary's Health System, Inc. ("SMHS"), has been in negotiations with Saint Francis Care, Inc. ("SFC") and Trinity Health Corporation ("Trinity Health"), relating to a certain Transfer Agreement by and among SMHS, Saint Mary's Hospital, Inc. ("SMH"), and Trinity Health (the "Transfer Agreement"), pursuant to which SFC (which will become the New England Regional Health Ministry ("NE-RHM") following completion of its transaction with Trinity) will become the sole corporate member of SMHS and serve as SMHS's parent (the "Transaction"; capitalized terms used but not defined herein shall have the meanings ascribed to them in the Transfer Agreement);

WHEREAS, the Board of Directors of SMHS and the Board of Directors of SMH (together, the "Boards") have reviewed from a financial, business, healthcare, operational, strategic and community perspective the proposed Transaction and having given due consideration to all matters that the Boards believe are necessary or appropriate to enable the Boards to reach a fully informed decision as to the advisability of the Transaction, deem it in the best interest of SMHS and SMH to consummate the Transaction and to enter into and perform their respective obligations under the Transfer Agreement and the Transaction Documents.

NOW THEREFORE, it is hereby:

**RESOLVED**: That the Boards believe it to be advisable and in the best interests of SMHS and SMH to consummate the Transaction.

**RESOLVED**: That SMHS and SMH enter into the Transfer Agreement, in substantially the form presented to the Boards and attached hereto as Exhibit A, and that the President and Chief Executive Officer of SMHS and SMH, respectively (collectively, the "Authorized Officer") be, and hereby is, authorized and directed to negotiate, execute and deliver in the name of SMHS and SMH the Transfer Agreement with such additions and modifications as such Authorized Officer deems, upon advice of financial advisors and counsel, necessary or appropriate and in the best interests of SMHS and SMH respectively, the execution and delivery of which shall be conclusive evidence of such Authorized Officer's approval thereof and authority thereunder; and be it further

**RESOLVED**: That SMHS and SMH enter into such applications, licenses, registrations, agreements, instruments, documents, and all such other Transaction Documents as such Authorized Officer may deem necessary or advisable to effectuate the Transaction and that such Authorized Officer be, and hereby is, authorized to negotiate, execute and deliver in the name of SMHS and SMH, respectively all such applications, licenses, registrations, agreements, instruments, documents and all such other Transaction Documents with such additions and modifications as such Authorized Officer deems, upon advice of financial advisors and counsel, necessary or appropriate and in the best interests of SMHS and SMH, respectively, in connection with obtaining all regulatory approvals, licenses, permits, consents, certificates, determination letters or other authorizations necessary or advisable to consummate the Transaction, the execution and delivery of which shall be conclusive evidence of such Authorized Officer's approval thereof and authority hereunder; and be it further

**RESOLVED**: That such Authorized Officer be, and hereby is, authorized to complete, execute and deliver in the name of SMHS and SMH, respectively such which such Authorized Officer in his sole discretion deems necessary or appropriate and in the best interests of SMHS and SMH , the execution and delivery of the foregoing to be conclusive evidence of such Authorized Officer's approval thereof and authority hereunder, and be it further

**RESOLVED**: That the officers of SMHS and SMH be, and each acting singly hereby is, authorized and empowered, in the name and on behalf of SMHS and SMH, to take or cause to be taken any and all actions and to execute and deliver or cause to be executed and delivered any and all agreements, resolutions, documents, certificates, reports and regulatory or other notices or filings, and to incur any and all fees and expenses necessary or appropriate in the opinion of such officer to effect the foregoing resolutions, which action or execution and delivery thereof shall constitute conclusive evidence of the authorization and approval of such action by SMHS and SMH; and be it further

**RESOLVED**: That all actions heretofore taken by any officer or director of SMHS and SMH in connection with or otherwise in contemplation of the matters contemplated by the foregoing resolutions be, and they hereby are, authorized, approved, ratified and confirmed in all respects.

62044606 v1

Saint Mary's
HEALTH SYSTEM

## Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.
## Special Boards of Directors Meeting
## Thursday, September 17, 2015

| Present | Staff Present | Excused |
|---|---|---|
| Robert J. Mazaika, Chair | Robert J. Anthony, Esq. (via phone) | Michael O'Brien |
| Rev. Monsignor James Coleman (via phone) | Ralph Becker | Jim Smith |
| Eric Albert (via phone) | Victoria Cipriano | |
| S. Mark Albini, M.D.(via phone) | Steve Schneider, M.D. | |
| Joseph Carlson (via phone) | | |
| Garrett Casey (via phone) | | |
| Stephen R. Griffin, Esq. | | |
| Robert Gumbardo, M.D. (via phone) | | |
| Michael Karnasiewicz, M.D. (via phone) | | |
| Sister Dolores Lahr, CSJ | | |
| Angela Mattie | | |
| Joseph Mengacci, Esq. (via phone) | | |
| Richard Pugh (via phone) | | |
| Felix Rodriguez (via phone) | | |
| Robert Roscoe (via phone) | | |
| Christine Sullivan, Esq. (via phone) | | |
| James Uberti, M.D. | | |
| Chad W. Wable | | |

**I. Call to Order & Opening Prayer**

Upon provision of due notice, the meeting of the Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. Boards of Directors was called to order by the Chairman, Robert J. Mazaika, at 7:00 a.m. with the opening prayer offered by Monsignor J. Coleman.

**II. Report of the Chairman**

**Report of Board Taskforce**

Mr. Mazaika advised that a revised Transfer Agreement and Board Resolutions were available via the SMHS Board Portal. He asked the Board if anyone had any questions or comments.

**Action:** Motion made and seconded to approve the transfer of SMHS and SMH membership to Trinity Health through the New England Regional Health Ministry and to change our juridical person to Catholic Health Ministries. Attorney Joseph Mengacci opposed the vote.

Mr. Mazaika reminded everyone to keep this information confidential for one more day. A formal signing of the documents will be held tomorrow, Friday, September 18, 2015, and at that time an announcement will be released to the public. Mr. Wable advised that Rick O'Connell, Executive Vice President of the East Group, and Chris Dadlez, Saint Francis Care, will attend the signing at 12 noon in the Auditorium.

Dr. Uberti congratulated and commended the Taskforce members past and present for their many hours of work.

Mr. Wable advised that the CON process is underway and will file legal notice immediately and anticipate filing a complete CON by November 30th.

**III. Announcements/Relevant Readings/Agenda Items**

Mr. Mazaika advised that the next SMHS/SMH Board Meeting will be held on September 24, 2015, Thursday: 7:00 a.m. – 9:00 a.m. in the Archbishop Daniel A. Cronin Boardroom.

**IV. Adjournment**

There being no further business, the meeting adjourned at 7:08 a.m.

Respectfully submitted,

Victoria Cipriano
Recording Secretary

Approved by,

Robert J. Mazaika
Chairman of the Board

# EXHIBIT 11

| Town | Discharges | % of Total |
|---|---|---|
| PLANTSVILLE | 42 | 0.36% |
| BETHLEHEM | 67 | 0.58% |
| MORRIS | 14 | 0.12% |
| THOMASTON | 156 | 1.34% |
| WATERTOWN | 621 | 5.34% |
| WOODBURY | 126 | 1.08% |
| BEACON FALLS | 69 | 0.59% |
| CHESHIRE | 184 | 1.58% |
| MIDDLEBURY | 176 | 1.51% |
| NAUGATUCK | 1,068 | 9.18% |
| OXFORD | 78 | 0.67% |
| PROSPECT | 389 | 3.34% |
| WATERBURY | 6,837 | 58.75% |
| WOLCOTT | 727 | 6.25% |
| PLYMOUTH | 73 | 0.63% |
| SOUTHBURY | 242 | 2.08% |
| Other | 768 | 6.60% |
| Total | 11,637 | 100.00% |

# EXHIBIT 12

# STATE OF CONNECTICUT

## Department of Public Health

## License No. 000055

## General Hospital

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

**Saint Mary's Hospital, Inc., Waterbury, CT**, d/b/a **Saint Mary's Hospital, Inc.** is hereby licensed to maintain and operate a General Hospital.

**Saint Mary's Hospital, Inc.** is located at **56 Franklin Street, Waterbury, CT**

32 Bassinets
347 General Hospital Beds

This license expires **December 31, 2016** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2015

Satellites:
Saint Mary's Department of Behavioral Health Care Services, 100 Jefferson Square, Waterbury, CT
Saint Mary's Hospital Urgent Care Center, 799 New Haven Road, Naugatuck, CT 06770
Saint Mary's Urgent Care Center, 503 Wolcott Road, Wolcott, Ct 06716
Naugatuck Valley Surgical Center, 160 Robbins Street, Waterbury, CT 06708
Saint Mary's Hospital Family Health Center, 95 Scovill Street, Waterbury, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

*CERTIFICATE OF WAIVER*

LABORATORY NAME AND ADDRESS

FRANKLIN MEDICAL GROUP, PC
799 NEW HAVEN ROAD
NAUGATUCK, CT 06770

LABORATORY DIRECTOR

PETER JACOBY, MD

CLIA ID NUMBER

07D1020707

EFFECTIVE DATE

12/30/2013

EXPIRATION DATE

12/29/2015

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Judith A. Yost

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

79 Certs1 120313

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
- If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.
- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.HHS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.



07/21/2015 11:42AM (GMT-04:00)

CENTERS FOR MEDICARE & MEDICAID SERVICES

# CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

## *CERTIFICATE OF WAIVER*

**LABORATORY NAME AND ADDRESS**

POND PLACE PEDIATRICS
166 WATERBURY RD, SUITE # 202
PROSPECT, CT 06712

**CLIA ID NUMBER**

07D2043173

**EFFECTIVE DATE**

06/28/2014

**LABORATORY DIRECTOR**

KAREN ELIZABETH KENNEDY DIR

**EXPIRATION DATE**

06/27/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

92 Certs1_060314

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PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

**CLIA ID Number: 07D2043173**
POND PLACE PEDIATRICS
56 FRANKLIN STREET
LAWLOR BLDG, 1 ST FLOOR
WATERBURY, CT 06706

**STATE AGENCY ADDRESS AND PHONE NUMBER:**

CLIA LAB PROGRAM/DEPT OF PUBLIC HEALTH

410 CAPITOL AVENUE, MS#12-HSR
PO BOX 340308
HARTFORD, CT 06134-0308
(860)509-7400

**LABORATORY MAILING ADDRESS:**

CENTERS FOR MEDICARE & MEDICAID SERVICES

# CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

*CERTIFICATE OF WAIVER*

LABORATORY NAME AND ADDRESS

FRANKLIN MECICAL GROUP PC
166 WATERBURY ROAD
PROSPECT, CT 06712

LABORATORY DIRECTOR
MARIE P LIVIGNI

CLIA ID NUMBER
07D1106888

EFFECTIVE DATE
10/23/2013

EXPIRATION DATE
10/22/2015

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Judith A. Yost

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Medicaid and State Operations

152 Certs_092413

CENTERS FOR MEDICARE & MEDICAID SERVICES

# CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

## *CERTIFICATE OF WAIVER*

**LABORATORY NAME AND ADDRESS**

WOLCOTT INTERNAL MEDICINE
503 WOLCOTT ROAD
1 ST FLOOR
WOLCOTT, CT 06716

**LABORATORY DIRECTOR**

LAURA C BRENES DIRECTOR

**CLIA ID NUMBER**

07D2043175

**EFFECTIVE DATE**

06/28/2014

**EXPIRATION DATE**

06/27/2016

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

93 Certs1_060314

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CENTERS FOR MEDICARE & MEDICAID SERVICES

# CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

## *CERTIFICATE OF WAIVER*

| LABORATORY NAME AND ADDRESS | CLIA ID NUMBER |
|---|---|
| FRANKLIN FACULTY PRACTICE<br>DBA FRANKLIN MEDICAL GROUP<br>133 SCOVILL ST, STE 102<br>WATERBURY, CT 06706 | 07D1028439 |
| **LABORATORY DIRECTOR** | **EFFECTIVE DATE** |
| | 07/23/2014 |
| **EXPIRATION DATE** | |
| JASON OUELLETTE MD DIRECTO | 07/22/2016 |

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Judith A. Yost

Judith A. Yost, Director
Division of Laboratory Services
Survey and Certification Group
Center for Clinical Standards and Quality

297

103 Certs1_062414

- If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.
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- If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

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# EXHIBIT 13

**PROFESSIONAL STATEMENT**

A PASSIONATE, CONTEMPORARY AND HIGHLY ACCOUNTABLE LEADER DEDICATED TO BUILDING ESSENTIAL RELATIONSHIPS WITHIN THE MEDICAL COMMUNITY AND BROADER COMMUNITY IN ORDER TO COME TOGETHER AS A TEAM TO TRANSFORM HEALTHCARE INTO A CONSUMER-ORIENTED SYSTEM OF REGIONAL HEALTHCARE SERVICES WITH THE RIGHT PATIENT RECEIVING THE RIGHT CARE IN THE RIGHT LOCATION RESULTING IN A VERY GOOD PATIENT EXPERIENCE THAT IS SUBSTANTIALLY BETTER QUALITY CARE, TRUSTED AND SAFE WHILE DRAMATICALLY REDUCING THE TOTAL COST OF CARE OVER TIME.

**EXPERIENCE**

**Saint Mary's Health System, Inc., Waterbury, CT**

Integrated network of healthcare services including Saint Mary's Hospital (347 beds), a Level 2 Trauma Center and NICU, Saint Mary's Hospital Foundation, Saint Mary's Indemnity Company, Naugatuck Valley Surgical Center, Harold Leever Regional Cancer Center, Heart Center of Greater Waterbury, Diagnostic Radiology of Southbury, Naugatuck Valley MRI, and Franklin Medical Group.
STATS: 12,000 admissions, 70,000 ED visits, 18,000 surgeries, 3 residency/teaching programs, $280 million in net revenues, 400 active members of the medical staff and 2,000 staff.

**President and Chief Executive Officer (2008-present)**

**Major Accomplishments:**

**Growth and Finance**

- ✓ One of seven hospitals in CT to achieve a positive five-year average operating margin.
- ✓ Increased DCOH from less than10 days to over 70 days.
- ✓ Lowest cost hospital in CT based on total cost per discharge.
- ✓ Established largest robotic surgery program in the region.
- ✓ Operate the largest freestanding surgical center in CT.
- ✓ Opened first community hospital based open heart and angioplasty program in CT.
- ✓ Aligned three physician groups into one large, integrated 100 provider multi-specialty group.
- ✓ Consolidated pediatric services in Waterbury with Connecticut Children's Medical Center establishing a hospital within a hospital at Saint Mary's Hospital.
- ✓ Established a hospital within a hospital partnership with VITAS for an inpatient hospice.
- ✓ Led the Board through an affiliation process resulting in multiple options for a transaction.
- ✓ Led the establishment of a wholly owned insurance company and risk management program.

**Service and Quality**

- ✓ Received the national quality performance award by the Joint Commission.
- ✓ One of Ten hospitals nationally selected to receive an ACC Patient Navigator Program Grant.
- ✓ Improved inpatient and ambulatory surgery HCAHPS more than 50 percentile points.
- ✓ Reduced patient falls and hospital acquired infection from over 200 to less than 100.
- ✓ Achieved top decile nationally for over 77% of all reportable CMS Core Measures.
- ✓ Achieved recognition five consecutive years by AHA *Get with the Guidelines* as a Gold Award Hospital for treatment of heart failure, MI and stroke.
- ✓ Achieved Consumer Reports safest hospital in CT 2013 and 2014.
- ✓ Recognized as a Top 100 Community Value Leadership Award Winner by Cleverley and Assoc.

**Executive Vice President, Strategy Development and System Operations (2008)**

**Vice President of Ambulatory Operations and Business Development (2003-2008)**

Responsible for strategic management, business development and community relations activities for the Health System. Responsible for all outpatient operations within the Health System with responsibility for growing market share, achieving Balanced Scorecard results and leading change within the organization.

**Major Accomplishments:**

- ✓ Served as a member of the senior management team responsible for successfully implementing a $24M financial turnaround plan.
- ✓ Led the planning, development and CON process for the establishment of a collaborative open heart and cardiac angioplasty program.
- ✓ Successfully recruited several physicians including several internists, breast surgeons, neurosurgeon, neurologist, cardiologists and a cardiothoracic surgical team.
- ✓ Led the development of a new Stroke Program consistent with the American Stroke Association *Get with the Guidelines* program.
- ✓ Led the development of a Bariatric Surgical Program in pursuit of accommodation as a Center of Excellence by the ASMBS and SRC.
- ✓ Established comprehensive community benefits program.
- ✓ Led the development of a comprehensive women's & breast services strategy including a new breast surgical practice and the development of diagnostic services.
- ✓ Led redesign of ambulatory care delivery system including six new outpatient facilities and enhanced technology resulting in over $1.0 million in annual incremental income.
- ✓ Introduced new patient advocacy program including patient rounding, real-time recovery process and a functional reporting system.
- ✓ Led team responsible for coordinating and developing an affiliation strategy including assessing local consolidation and national partnership options.
- ✓ Led the redesign of a primary care network of hospital sponsored and private practices.
- ✓ Led the establishment of the first freestanding hospital-owned MRI Center in Waterbury.

**Corporate Director of Strategic Planning and Business Development (2002-2003)**

Responsible for leading the Board and Senior Management through a comprehensive strategic planning process resulting in the first system-wide long range strategic plan including master facility, medical staff development, quality improvement, image improvement, information systems and long range financial plans. Provided management support for marketing, community relations, medical staff development, imaging services, health information management, plant operations and support services. Reported directly to President & CEO.

**Major Accomplishments:**

- ✓ Lead annual strategic planning process including annual update of a five year strategic plan.
- ✓ Designed and administered a Balanced Scorecard for enhancing relationships, clinical effectiveness and improving operating performance.
- ✓ Led the completion of a comprehensive master facility plan including optimizing the current facility and long term options for rebuilding in place and new construction.
- ✓ Led the completion of the medical staff development plan including a community needs assessment, physician satisfaction survey and the establishment of physician recruiting policies, procedures and strategies.
- ✓ Designed and implemented an image improvement strategy including the redesign of the marketing and community relations functions resulting in dramatically improved brand identity and consumer perception.
- ✓ Led redesign of imaging services including establishment of a new professional services agreement with a local radiology group.
- ✓ Led team responsible for improved charge capture and front-end revenue cycle improvement.

**Monongalia Health System, Inc., Morgantown, WV**

Integrated network of healthcare services including Mon General Hospital, The Foundation of Mon General Hospital, MonHealthcare Equipment & Supplies, Monongalia EMS, The Village at Heritage Point, Healthworks Rehab & Fitness, Care Partners, HealthSouth Rehab Hospital.

**Director of Strategic Planning and Business Development (2000-2002)**

**Strategic Analyst (1999-2000)**

**Post-graduate Fellowship, Healthcare Administration (1999)**

**West Virginia University, Morgantown, WV**

**Instructor, Community Health Education (1998-1999)**

## EDUCATION

**West Virginia University, Morgantown, WV**
Master of Business Administration, August 2002
Master of Science in Community Health Education, December 1999
Master Certificate in Healthcare Administration, December 1999
Bachelor of Science in Biology, May 1998

## PROFESSIONAL AFFILIATIONS/CERTIFICATIONS

American College of Healthcare Executives – Fellow
American Hospital Association, Metropolitan Governing Board
Connecticut Hospital Association – Board of Directors
CT Chapter American College of Healthcare Executives – Board of Directors
Certified High Reliability Trainer through HPI
Six Sigma Green Belt with Lean and Workout Training through Juran Institute

## COMMUNITY SERVICE

United Way of Greater Waterbury, Board of Directors, Chairman (2010-2012)
Greater Waterbury YMCA, Board of Directors
Waterbury Regional Chamber of Commerce, Board of Directors
Saint Bridget's School, Board of Directors
Rezziliant, Inc., Board of Advisors (2005-2010)
Visiting Nursing Association, Board of Directors (2004-2007)

## AWARDS AND HONORS

Connecticut Magazine 40 under 40 Award recipient (2011)
Modern Healthcare Magazine "Up & Comers" Award recipient (2010)
American College of Healthcare Executives, Early Careerist Award, Connecticut Chapter (2006)
West Virginia University, Varsity Football

- Big-East Conference Scholar-Athlete first team (1994-1997)
- Ira E. Rogers Award for high leadership, academic qualities, and football performance (1997)

# Ralph W. Becker

255 Hobart St, Southington, CT 06489
rwbecker@cox.net
Cell: 203-537-5412
Home: 860-426-9207

**1985 – 2013 Midstate Medical Center, Meriden, Connecticut** www.midstatemedical.org
**Midstate is a 144 bed hospital with $200 million in annual net revenues.**
**Midstate is part of the Hartford Healthcare System.**

**Vice President and CFO**
Responsible for all financial reporting, budgeting, financings, managing managed care, revenue integrity / enhancement, physician financial agreements and ventures. Currently oversee Finance, Accounting, Budgeting; have previously overseen Health Information Management (Medical Records), Materials Management, and Service Access. Also, Chair the hospital's Risk Management Committee. Report to the hospital CEO and the CFO for the system.

*Significant accomplishments:*
Instrumental in maintaining consistently positive operating results in a changing environment for more than a decade. Feasibility analysis, Certificate of need preparation, and financial oversight of a hospital merger, then subsequent construction of a new hospital at a new location. Coordinated feasibility analysis and financings for multiple building programs (most recently a major expansion within the last 4 years). Established and oversee a multi-disciplinary revenue enhancement (revenue cycle) function (for more than a decade). Responsible for achieving very favorable managed care rates and terms; the hospital's "private payment to cost" ratio averages 1.4 (best in Connecticut) for many years. Helped build a positive relationship with our affiliated physicians. Served on the Board of Directors as CFO of the PHO.

**1981- 1985 Ernst & Young (formerly Ernst & Whinney) Hartford Connecticut.**
**Senior Consultant (health care consulting team).**
Oversight or involved with various consulting engagements (including reimbursement, cost reporting, revenue enhancement, feasibility studies).

**1974- 1981 Anthem Blue Cross (formerly Blue Cross & Blue Shield of Connecticut)**
**Positions progressing to Senior Reimbursement Analyst / Auditor.**
Oversight or involved in Medicare Audit and Reimbursement functions.

**Education:**
MBA Finance – University of New Haven, New Haven Connecticut
BS in Finance – Norwich University, Northfield Vermont
**Community:** Served on Executive Committee and Board of Directors of the Quinnipiac Chamber of Commerce (Wallingford and North Haven Connecticut) for 11 years

# CHARLES M. FLINN, FACHE

214 West Chestnut Street - Unit 303
Kingston, New York 12401

(Cell) 845-399-5992
Email: chip.flinn@gmail.com

## SUMMARY OF EXPERIENCE:

Highly visible, results-oriented health care executive with 16 years in leadership. Effective communicator with strong clinical, quality and fiscal skills, experienced in change management, the ability to align diverse stakeholders, and develop employee, medical staff and board relations. Strategic, quality-focused leader with distinguished performance in process improvement and system integration utilizing Lean and Six Sigma acumen. Proven abilities include programmatic development leading to a national "number one in overall patient satisfaction" award from The Jackson Group (NRC Picker).

## PROFESSIONAL EXPERIENCE:

**Executive Vice President-COO** **HealthAlliance of the Hudson Valley, Kingston, NY** **2009-Present**

Executive Vice President of two long-standing, fiercely competitive community hospitals situated less than 1 mile apart. Under Berger Commission edict, initiated strategy and execution of plan to combine into a financially successful integrated healthcare delivery system.

- Set strategies and goals to achieve financial performance targets over two hospitals, all ambulatory, behavioral health, support and emergency services;
- Completed $22.5M in capital projects, including new ORs, ED, clinical consolidations of nursing units;
- Aligned and rebuilt diverse workforce of 2,400 through training in contemporary management to build one seamless organization;
- Development of clinical integration model for 78 primary care physicians striving towards an ACO model;
- Developed physician-centric Centers of Excellence in Breast Health, Ortho & Vascular Surgery;
- Combined two emergency departments into one 50,000 visit department and accomplished a positive $2M revenue enhancement project while improving organizational throughput;
- Negotiated new annual contracts with EM Group, Radiologists and BMS provider through RFP processes;
- Restructured physician practice model from employed model to private office practice at the critical access hospital – decreased expenses in excess of $320,000;
- Completely re-engineered care delivery model for behavioral health service line turning around a deficit to a $1.2M favorable contribution margin while improving patient outcomes significantly;
- Re-designed, raised funding for and construction of $1.6M oncology infusion, breast health and pre-surgical centers; and
- Awarded HealthGrades Top 5% award for Patient Safety.

**Vice Chair, Operating Committee** **Hudson Health Partners, Newburgh, New York** **2011-Present**

Established in 2012, Hudson Health Partners is a controlled for-profit joint venture corporation linking four Hudson Valley hospital systems into a single, non-asset merged healthcare corporation focused on employee self-insurance, physician centric care management improvements and continuum of care coordination pre- and post hospital. Through contiguous geographic scale, HHP serves Orange, Rockland, Dutchess and Ulster counties, encompassing a scope of 1.1 M in population, 1,200 physicians and collective operating budgets of over $1 billion.

- Quality initiatives and best practices to ensure that residents of the region have access to exceptional care;
- Clinical collaborations including population health and wellness initiatives to enhancement and expansion of care delivery throughout the region;
- Physician Services including recruitment, medical education, Electronic Health Records, and practice management services.
- Hospital services, pilot projects/incubators, clinical care paths and shared support services.
- Enhanced efficiencies gained through population management, group purchasing and sharing of resources to reduce costs.

**Vice President-Chief Administrative Officer** **Saint Clare's Health System, Denville, NJ** **2005-2009**

Vice President of $300M, multi-campus healthcare system serving a community population exceeding 300,000 in northwest New Jersey. Total 500 licensed beds with direct operational oversight of Nursing (Med/Surg, ED, ICU, OR, L&D, PACU, Oncology, Cardiac Cath and Peripheral labs), Laboratory, Radiology, Cardiology, Respiratory, Endoscopy, Women's Health, Emergency Medical Services and Support Services. Service Line Executive and Champion for Women's Health, Minimally Invasive Orthopedic and Robotic Surgery, Cardiac and Vascular Programs and Inpatient/Outpatient imaging

- Developed of tri-annual strategic plans, including joint ventures with cardiology and vascular surgeons;
- Launch of the Miracles Campaign - a community philanthropic initiative to raise $200M from community, employees and medical staff;
- Constructed $11M mother/child center - the Katena Center - on-time and under budget;
- Partnered with physicians to design and develop a pediatric neuro-epilepsy program and inpatient unit;
- Increased market share of emergency medical services by more than 16% over two-year period;
- Led community and state approvals (DOH, DEP, DEC) for $75MM patient access/parking structure
- Achieved approval for State primary stroke center designation;
- Led organization from concept through completion of $3.8MM interventional labs;
- Improvement of radiology cycle and waiting times by 37% reduction, utilizing Lean Six Sigma methods;
- Opened an Outpatient Imaging Center, $1.9M on-time and on-budget;
- Aggressive efforts to develop a "high-technology/high-touch" culture;
- Planned the region's first 30-minute *'Door to Doctor'* program in the Emergency Department;
- Enhanced medical staff relations (~748 credentialed staff), fostering relationships to partner with administration;
- Purchased and implemented a daVinci Robot for minimally invasive urologic and gynecologic surgery;
- Improved oncology program with enhanced care delivery utilizing Tomo-Therapy radiation in new center of excellence - Cancer Care at Saint Clares;
- Improved financial performance with developed financial dashboards; demonstrated 37% performance increase.

**Director, Emergency Services** **St, Joseph's Mercy of Macomb Hospital** **2004-2005**
**Clinton Township, Michigan**

Responsible for daily business operations of Emergency Department with $9M annual budget, 54,000 annual visits, 10,000 of which resulted in admissions. Developed strong leadership of nursing and physicians and liaison with all clinical and non-clinical departments. Managed 30-minute guarantee for patients - 97% efficiency; leading to 85th percentile NRC patient satisfaction.

**Executive Director-Patient Access** **University of Medicine & Dentistry of New Jersey** **2002-2004**
**Newark, New Jersey**

Responsible for daily business operations of Emergency Department with $19 Million annual budget, 76,000 ED visits, 13,000 admissions for a 430 bed academic hospital, ACS Accredited Level I Trauma Center. Executive oversight of bed control, out-patient registration and admitting – Matrix Reporting structure.

- Awarded "Runner-Up" for best performance improvement project FY03;
- *"Decreasing Medical Screening Exam-A Pilot Study"* - July 2002;
- Nominated for Modern Healthcare's *"Up and Comer Award"* for significant achievement in healthcare;
- Reduced "missing charts" from ~120/month to <5/month in Q1 FY04 through rapid design process improvement;
- Identified root-causes of unbilled revenue of the outpatient revenue;
- Administrative Champion for MedAptus physician (professional) billing software via "palm" device and wireless network;
- Developed and implemented "balanced scorecard" for performance improvement metrics; and
- Completed design and construction of $14 million renovation of emergency department.

**CFO--Department of Surgery** **University of Medicine & Dentistry of New Jersey, Newark, NJ** **2002-2004**
**Administrative Director** **Good Samaritan Hospital Medical Center, West Islip, New York** **1998-2002**

**EDUCATION:**

| | |
|---|---|
| Dowling College, Oakdale, New York, Master of Business Administration-Management | 2002 |
| St. Joseph's College, Patchogue, New York, Bachelor of Science-Healthcare Administration | 2000 |

**PROFESSIONAL AND BOARD MEMBERSHIPS:**

| | |
|---|---|
| American College of Healthcare Executives (ACHE), Fellow | 2007 |
| HANYS Chief Operating Officers Committee | 2009 |
| NORMET Patient Safety Organization | 2010 |

# CHRISTOPHER M. DADLEZ, FACHE

**HOME:**
9 Cobtail Way
Simsbury, CT 06070
(860) 2167-1648
CDadlez@aol.com

**OFFICE:**
Saint Francis Hospital and Medical Center
114 Woodland Street, Hartford, CT 06105
(860) 714-5541 Fax (860) 714-7920
CDadlez@stfranciscare.org

## SUMMARY

A healthcare career of 30 years successfully leading and managing large, complex organizations.

## PROFESSIONAL EXPERIENCE

**PRESIDENT AND CHIEF EXECUTIVE OFFICER**
Saint Francis *Care*, Inc.
Saint Francis Hospital and Medical Center
(2004 to present)

Saint Francis Hospital and Medical Center has been an anchor institution in North Central Connecticut since its founding in 1897 by the Sisters of Saint Joseph. Licensed for 617 beds, it is one of the largest hospitals in Connecticut and is the largest Catholic hospital in New England. We are a multidisciplinary, leading-edge teaching hospital.

Saint Francis affiliated with Mount Sinai Hospital in 1990 to create a new regional healthcare system. This was the first recorded instance of a merger between a Catholic hospital and a Jewish hospital in United States history. In October 1995, the two institutions completed a formal corporate merger.

A regional referral center, Saint Francis provides sophisticated, contemporary medicine with major clinical concentrations in cardiology, orthopedics, oncology, orthopedics, women's services and rehabilitation. The achievement of excellence is emphasized through centers of excellence, which focus on quality, caring and the dignity of every patient.

Saint Francis has been named a Solucient "Top 100 Hospital" seven times, a "Top 100 Cardiac Program" three times, and a "Top 100 Performance Improvement Hospital" twice. It is also the recipient of the Leapfrog Top 50 Hospitals award and has been recognized by Care Science Top 1% of all hospitals in clinical outcomes.

**PRESIDENT AND CHIEF EXECUTIVE OFFICER**
CSAHS/UHHS-Canton, Inc.
Mercy Medical Center
(2000-2003)
CSAHS/UHHS, Inc. is the not-for-profit Partnership representing the Sisters of Charity of St. Augustine Health System (CSAHS) and University Hospitals Health System (UHHS) of Cleveland. The Partnership operates Mercy Medical Center in Canton, Ohio and its regional health centers in North Canton, Carrollton, Jackson Township, Louisville, and Dover, Ohio

Responsible for efficient and effective operation and strategic direction of the organization reporting directly to the Partnership Board.

Mercy Medical Center was named a "Top 100 Hospital" for 2001 and 2002, Top 100 Cardiovascular Services Hospital for 2001 and 2002 and a Top 50 U.S. News & World Report Best Hospital for cardiovascular services for 2001 and 2002. In 2001 Mercy received the prestigious AHA Nova Award for innovative community outreach programs. For the last three years Mercy has attained record numbers in admissions, outpatient visits, net revenue and productivity.

# CHRISTOPHER M. DADLEZ, FACHE

**EXECUTIVE VICE PRESIDENT**
Saint Barnabas Health Care System
(1996 to 2000)
Parent company of the largest healthcare provider in New Jersey. This 2 billion-dollar annual revenue company consists of ten acute-care hospitals, one children's hospital, 48 ambulatory centers, 23,000 employees, 4,000 physicians and 450 medical residents.

Member of the Office of the President/Executive Management Committee. Responsible for the strategic direction and centralized management of this dynamic organization. System-wide responsibilities include all clinical integration, development of center(s) of excellence, product line operations, marketing and development, and graduate medical education.

**PRESIDENT AND CHIEF EXECUTIVE OFFICER**
**MID-ATLANTIC HEALTH GROUP**
Parent company of Monmouth Medical Center. Monmouth Health Care foundation: Mid-Atlantic Health Care: Monmouth Chemical Dependency Treatment Center, MA Resources and Monmouth Medical Surgi Center, Inc. Merged this holding company with two other organizations to form the new Saint Barnabas Health Care System.

**PRESIDENT AND CHIEF EXECUTIVE OFFICER**
**MONMOUTH MEDICAL CENTER**
(1992-1996)
Responsible for the efficient and effective operation and strategic direction for this 526-bed community teaching hospital (with 2,000 FTEs and an operating budget of $170 million). Affiliated with the Medical College of Pennsylvania and Hahnemann University

**EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER**
**SINAI HOSPITAL BALTIMORE, MD**
(1986-1992)
**EXECUTIVE VICE PRESIDENT**

**SINAI HEALTH SERVICES**
(1986-1992)
**VICE PRESIDENT**
(1984-1986)
Responsible for the day-to-day operation of this 467-bed teaching hospital and medical center. Affiliated with the Johns Hopkins Medical School and with an operating budget exceeding $190 million and 2,700 FTEs. All aspects of this organization reported to the COO with the exception of Finance. Advised the President on operational and strategic policy. Member of Medical Staff and Board Executive Committees. Served as Chief Operating Officer of holding company, which had responsibility for all hospital-affiliated corporations. Acted as CEO during absence of President.

**ASSISTANT ADMINISTRATOR**
**GREATER LAUREL BELTSVILLE HOSPITAL**
**LAUREL, MD**
(1981-1984)
Assistant Administrator of 236-bed acute-care facility which was part of a 900-bed multi-unit system.

**ASSISTANT ADMINISTRATOR**
**WAYNESBORO HOSPITAL**
**WAYNESBORO, PA.**
(1979-1981)
Acting CEO from 1979 to 1980 while recruiting permanent CEO. Responsible for managing all operations of the hospital

**ADMINISTRATIVE FELLOW** – 4/79-12/79
**ADMINISTRATIVE RESIDENT** – 8/78-7/79
**EVENING ADMINISTRATOR** – 7/77-8/78
**RICHMOND MEMORIAL HOSPITAL**
**RICHMOND, VA.**

# CHRISTOPHER M. DADLEZ, FACHE

## EDUCATION

Loyola College, Baltimore, MD
Advanced Graduate Course in Business and Finance
Medical College of Virginia, Virginia Commonwealth University
Richmond, VA Masters in Hospital Administration 1979
University of New Hampshire, Durham NH
Bachelor of Arts, Biology 1975

## MEMBERSHIPS & APPOINTMENTS

Alliance of Independent Academic Medical Centers (AIAMC)
Board of Directors and Executive Committee – 2005 to present
American College of Healthcare Executives (ACHE) – Fellow – 1990 to present
American Hospital Association Regional Policy Board – Alternate Delegate and Delegate – 2007 to present
American Hospital Association Equity of Care Committee – 2011
American Hospital Association Fellow in Healthcare Reform - 2011
Association of American Medical Colleges (AAMC) – Member – 1984 to present
Business Hall of Fame – 2011
Council of Teaching Hospitals and Health Systems (COTH) – Member – 1984 to present
Council for Accreditation of Health Management Education – Surveyor – 2006 to present
Catholic Health Association (CHA) – Member – 2000 to present
Connecticut Hospital Association – Board of Directors – 2006 to present
Chairman, Board of Directors – 2010 to present
Vice Chairman, Board of Directors – 2008 to 2010
Chairman, Finance Committee – 2006 to present
Capital Area Health Consortium – Member – 2004 to present
Connecticut Catholic Hospital Council – Member – 2004 to present
Connecticut Catholic Conference – Member – 2004 to present
Governor's Task Force on Hospital Reform – Member – June to December 2007
Governor's Connecticut Healthcare Reform Advisory Board – 2009-2010
Medical College of Virginia, Department of Healthcare Administration
Alumni Executive Committee and Past President
Adjunct Faculty/Lecturer/Preceptor

Ohio Hospital Association
Research & Education Foundation Board of Directors 2001 to 2003
Committee on Workforce Crisis Board of Directors 2001 to 2003
Akron Regional Hospital Assoc. Board of Directors 2003
University Hospitals Regional Network Board of Directors 2000 to 2003
Premier Health Alliance – Chicago, IL – Board of Trustees and various committees (1993 to 1996)
New Jersey Hospital Association (1993 to 2000)
NJHA – Treasurer
NJHA – Chairman, Finance Committee
NJHA – Investment Committee
NJHA – Chairman of the Political Action Committee
NJHA – Member of the Board of Trustees/Executive Committee
NJHA – Member of Health, Research and Educational Trust of New Jersey – Board of Directors
NJHA – Member for Center for Health Affairs Board
NJHA – Past Chairman, Integrated Delivery System Committee
NJHA – Past Chairman, Committee on Managed Care
NJHA – Member of Visioning and Strategic Planning Committee
NJHA – Member of Select Committee for Development of New Payment System
NJHA – Member of Membership Committee
NJHA – Member of Executive Compensation Committee
New Jersey Joint Teaching Hospital Forum
First Option Health Plan of New Jersey, Founder/Board of Trustees/Executive Committee
Council of Teaching Hospitals – Delegate to American Association of Medical Colleges

# CHRISTOPHER M. DADLEZ, FACHE

American Hospital Association – Political Action Delegate
Johns Hopkins University, Department of Healthcare Administration
Adjunct Faculty/Lecturer/Preceptor

## ITEMS OF NOTE

Served as faculty member and speaker at many national healthcare conferences and have appeared on television and radio programs to discuss all aspects of the healthcare field. In 1992 received the CAPE award for the finest healthcare program aired on cable television in New Jersey.

## CONNECTICUT COMMUNITY SERVICE

| | | |
|---|---|---|
| Governor's Council on Economic Competitiveness and Technology | Member | 2006 to present |
| MetroHartford Alliance | Board of Directors | |
| Diversity and Inclusion Committee | Chairman | 2005 to present |
| Malta House of Care | Board of Directors | 2006 to present |
| Mayor's Healthy Communities Initiative | Member | 2005 to present |
| Committee to End Chronic Homelessness | Member | 2005 to 2006 |
| Greater Hartford Arts Council | Member | 2006 to present |
| Bushnell Ovations Committee | Member | 2005 to 2006 |

## OHIO COMMUNITY SERVICE

| | | |
|---|---|---|
| United Way | Board of Directors | 2001 to 2004 |
| Catholic Charities | Board of Directors | 2001 to 2004 |
| Walsh University | Board of Directors | 2001 to 2004 |
| Boy Scouts of America | Board of Directors | 2001 to 2004 |
| Canton Central Catholic High School | Board of Directors | 2001 to 2004 |
| YMCA | Board of Directors | 2001 to 2004 |
| Stark County Development Board | Board of Directors | 2001 to 2004 |

## PRIOR COMMUNITY SERVICE

Asbury Park Soup Kitchen
American Cancer Society
American Heart Association – 1995 Service Award
Catholic Charities
Founder and Chairman, Long Branch Tomorrow
Ronald McDonald House – Board of Trustees
Monmouth Chemical Dependency Center – Board of Trustees
Long Branch Chamber of Commerce – Board of Directors
Children's Psychiatric Center
Girl Scouts – Monmouth Council
Juvenile Diabetes Foundation – Chaired 1996 "Walk for the Cure"
Honored as Long Branch "Man of the Year 1994"
March of Dimes – Chaired "Walk America"
Monmouth University
United Cerebral Palsy – 1995 Service Award
Honored in 1996 by the Urban League with the Founder's Award

## PERSONAL

Born June 16, 1953
Married 34 years to Eileen
Children: Nina age 26 Greg age 24

## HOBBIES

Tennis, running, soccer, reading, French

# Curriculum Vitae

| | |
|---|---|
| Name | John F. Rodis, M.D. |
| Date of Birth | December 27, 1955 |
| Place of Birth | Brooklyn, New York |
| Home Address | 46 Dorset Lane<br>Farmington, Connecticut 06032-2330 |
| Office Address | Saint Francis Hospital and Medical Center<br>Department of Obstetrics and Gynecology<br>114 Woodland Street<br>Hartford, Connecticut 06105 |
| Telephone | Office: (860) 714-4457<br>Home: (860) 678-1218 |
| Martial status | Marytherese Conway - October 2, 1987 |
| Children | Alexandra - September 8, 1989<br>Katrina - May 7, 1992<br>Anna - May 22, 1995 |

**Education**

| | |
|---|---|
| 1972-1976 | BA- Biology<br>Cornell University<br>Ithaca, New York |
| 1976-1980 | MD<br>Autonomous University of Guadalajara<br>Guadalajara, Mexico |
| 1980-1981 | Fifth Pathway<br>St. Joseph's Hospital & Medical Center<br>Paterson, New Jersey |
| 1981-1985 | Resident, Obstetrics and Gynecology<br>St. Joseph's Hospital & Medical Center<br>Paterson, New Jersey |
| 1985-1987 | Fellowship in Maternal-Fetal Medicine<br>University of Connecticut Health Center<br>Farmington, Connecticut |

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| | 1993-1996 | Fellowship in Human Genetics<br>Department of Pediatrics<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| | 2005 | Six Sigma Green Belt Certification |
| | 2007 | American College of Physician Executives PIM Course |
| Licensure | New Jersey<br>Connecticut<br>New York | 40792<br>26709<br>158721 |
| Boards | 1989 | Board Certified, American Board of Obstetrics and Gynecology |
| | 1990 | Sub-Specialty Certification, Certified by the Division of Maternal-Fetal Medicine, American Board of Obstetrics and Gynecology |
| | 1998 | Passed Recertification Examination in Obstetrics and Gynecology and Maternal-Fetal Medicine |
| Appointments | 1985-1987 | Instructor, Obstetrics and Gynecology<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| | 1987-1993 | Assistant Professor, Obstetrics and Gynecology<br>Division of Maternal-Fetal Medicine<br>Director of Perinatal Genetics<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| | 1987-1995 | Assistant Professor, Department of Pediatrics<br>School of Medicine,<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| | 1987 - 2001 | Attending Obstetrician and Gynecologist<br>Specializing in Maternal-Fetal Medicine<br>St. Francis Hospital & Medical Center<br>Hartford, Connecticut |

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|---|---|
| 1987 - 2001 | Associate Attending Obstetrician and Gynecologist<br>Specializing in Maternal-Fetal Medicine<br>New Britain General Hospital<br>New Britain, Connecticut |
| 1991-1993 | Residency Coordinator<br>Department of Obstetrics and Gynecology<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| 3/93 – 6/01 | Residency Program Director<br>Department of Obstetrics and Gynecology<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| 3/93 – 6/01 | Associate Professor, Obstetrics and Gynecology<br>Division of Maternal-Fetal Medicine<br>Director of Perinatal Genetics<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| 1995 – 6/01 | Associate Professor, Department of Pediatrics<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| 1/99 – 6/01 | Professor, Obstetrics and Gynecology<br>Division of Maternal-Fetal Medicine<br>Director of Perinatal Genetics<br>University of Connecticut Health Center<br>Farmington, Connecticut |
| 7/01-3/04 | Chairman, Obstetrics and Gynecology<br>Stamford Hospital<br>Stamford, Connecticut |
| 9/01-5/13 | Professor of Clinical Obstetrics and Gynecology<br>Columbia University College of Physicians and Surgeons<br>New York, New York |
| 7/11-present | Chair, Department of Obstetrics and Gynecology<br>Director, Women & Children's Health Services<br>Saint Francis Hospital and Medical Center<br>Hartford, Connecticut |

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|---|---|
| 2/13-Present | Saint Francis Faculty Fellow<br>Saint Francis Hospital Education Council<br>Hartford, Connecticut |
| 5/13-present | Professor, Department of Obstetrics and Gynecology<br>University of Connecticut Health Center<br>Farmington, Connecticut |

Awards

| | |
|---|---|
| 1993 | APGO Excellence in Teaching Award, sponsored by APGO Medical Education Foundation |
| 1998 | CREOG National Faculty Teaching Award, sponsored by CREOG |
| 2001 | CREOG National Faculty Teaching Award, sponsored by CREOG |

Societies

Fellow, American College of Obstetrics and Gynecology
Member, Society for Maternal-Fetal Medicine
Connecticut Perinatal Association
Member, American Institution of Ultrasound in Medicine
International Society of Perinatal Obstetricians
Associate Member, Society of Gynecologic Investigation
New England Perinatal Society - Secretary - 1996-1997
New England Perinatal Society - Vice President 1997-1998
New England Perinatal Society - President 1998-1999
Association of Professors in Gynecology and Obstetrics
Hartford County Medical Association
Connecticut State Medical Society
American College of Physician Executives

Committee Appointments

John Dempsey Hospital/University of Connecticut School of Medicine

| | |
|---|---|
| 1986-88 | Transfusion Committee |
| 1987-90 | John Dempsey Hospital Quality Assurance/Peer Review Committee |
| 1987-90 | Chairman, Obstetrics and Gynecology Quality Assurance/Peer Review |
| 1990-2001 | Transfusion Committee |
| 1996-2001 | Clinical Practice Subcommittee of the Clinical Governance Committee |
| 1996 | Clinical Research Task Force |
| 1995-2001 | Committee for Graduate Medical Education |
| 1997-2001 | Chairman, Operations Subcommittee of Committee for Graduate Medical Education |
| 1998 | Search Committee for OB/GYN Chair |
| 1990-2001 | Chairman, CADCARS Review Committee Others |
| 1999-2001 | Chairman, Committee on Graduate Medical Education |
| 2002-2004 | At-large Member, Medical Board |

Stamford Hospital Committees/Positions

| | |
|---|---|
| 2002-2004 | Chair, Department of Obstetrics and Gynecology |
| 7/01/03- 2011 | Senior Vice President Medical Affairs, Chief Medical Officer |
| 2001-2003 | Blood Bank Committee |
| 2001-2011 | Patient Safety Committee |
| 2001-2011 | OR Committee |
| 2002-2011 | Credentials Committee |
| 2003-2011 | Strategy and Market Development Committee (Board Committee) |
| 2003-2011 | Medical Executive Committee |
| 2003-2011 | Bylaws Committee |
| 2003-2011 | Clinical Leadership Council |
| 2003-2011 | Quality and Clinical Affairs Committee (Board Committee) |
| 2003-2011 | Ops Council |
| 2003 | Chair- Credentials Task Force |
| 2003 | Chair, Ob/Gyn Chair Search Committee |
| 2004 | Chair, Surgery Chair Search Committee |
| 2004 | Emergency Department Chair Search Committee |
| 2002-2004 | Medical Board |
| 2005 | Chair, Pathology Chair Search Committee |
| 2006 | Co-Chair, Radiology Chair Search Committee |

Saint Francis Hospital and Medical Center Committees/Positions

| | |
|---|---|
| 2011–present | Chair, Department of Obstetrics and Gynecology |
| 2011-present | Director, Women & Infants Health Services |
| 2011-present | Co-chair, Women & Infants Quality and Practice Council |
| 2011-present | Medical Staff Quality Committee |
| 2011-present | St. Francis Medical Group Board of Directors |
| 2011-present | Chiefs' Forum |
| 2011-present | Capitol Budget Committee |
| 2011-present | IT Executive Steering Committee |
| 2011–present | Surgical Service Performance Improvement Committee |
| 2011-present | OR Steering Committee |
| 2012-present | Quality & Patient Safety |

Others (State and National Ob/Gyn Educational Organizations)

| | |
|---|---|
| 1989-1995 | Connecticut Hospital Association Committee on Quality Assessment, Chairman, Panel on Obstetrics |
| 1995-2011 | Committee on Quality Assessment, Connecticut Hospital Association |
| 1998 -2001 | Alternate Program Director Representative for Region I - Council on Resident Education in Obstetrics & Gynecology |
| 1999-present | American Board of Obstetrics and Gynecology Oral Board Examiner |
| 2009-2011 | Chair, Chief Medical Officer Group, New York-Presbyterian Healthcare System |

Editorial consultation

American Journal of Obstetrics and Gynecology
Obstetrics and Gynecology
Journal of Clinical Ultrasound
American Journal of Perinatology
Journal of Maternal-Fetal Medicine
Connecticut Medicine- Associate Editor

Grants/Clinical Trials:

NIH grant 1991, "Study of CF carrier screening in primary care settings", Robert M. Greenstein (Principal investigator), John F. Rodis, MD, (Co-Principal Investigator)

CT Research Foundation 1988, "Role of Chlamydia and mycoplasma in villus sampling", John F. Rodis, MD, (Principal investigator)

Adolor Corporation Protocol 14CL306: A Multicenter Phase III, Double-Blind, Placebo-Controlled, Study of ADL8-2698 in Opioid-Induced Postoperative Bowel dysfunction/Postoperative Ileus in Subjects Undergoing Total Abdominal hysterectomy (Principal Investigator)

Publications

1. Cusick W, Leuci D, Viscarello RR, Rodis JF. Anaphylactoid syndrome of pregnancy after intracervical dinoprostone for cervical ripening: a report of 3 cases. J Reprod Med 50:225-228, 2005

2. Cusick W, Provenzano J, Sullivan CA, Gallousis FM, Rodis JF. Fetal nasal bone length in euploid and aneuploid fetuses between 11 and 20 weeks' gestation: a prospective study. J Ultrasound Med 23:1327-1333, 2004

3. Feldman DM, Borgida AF, Rodis JF, Leo MV, Campbell. A randomized comparison of two regimens of misoprostol for second-trimester pregnancy termination. Am J Obstet Gynecol 189:710-713, 2003

4. Cusick W, Stewart J, Parry M, McLoed G, Rakos G, Sullivan C, Rodis J. State mandated prenatal human immunodeficiency virus screening at a large community hospital. Conn Med 67:7-10, 2003

5. Egan JF, Rodis JF, Benn PA. Ultrasound markers of Fetal Down Syndrome. JAMA 285:2856-2857, 2001

6. Feldman DM, Borgida AF, Trymbulak WP, Sanders MM, Barsoom MJ, Rodis JF. Clinical implications of velementous cord insertion in triplet gestations. Am J Obstet Gynecol 184:809-811, 2002

7. Benn PA, Gainey A, Ingardia CJ, Rodis JF, Egan JFX. Second trimester maternal serum analytes in triploid pregnancies: correlation with phenotype and sex chromosome complement. Prenatal Genetics 21:680-686, 2001

8. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX. Outcomes of pregnancies complicated by ruptured membranes after genetic amniocentesis. Am J Obstet Gynecol 183:937-939, 2000

9. Feldman DM, Borgida AF, Rodis JF, Campbell WA: Irreversible maternal brain injury during pregnancy: a case report and review of the literature. Obstet Gynecol Survey 55:708-714, 2000

10. Barsoom MJ, Prabulos AM, Rodis JF, Turner GW: Vanishing gastroschisis and short bowel syndrome. Obstet Gynecol 96:818-819, 2000

11. Ling PY, Leo MV, Turner G, Rodis JF, Campbell WA. Amnioreduction in triplet fetofetal transfusion. Obstet Gynecol 96:843, 2000

12. Egan JFX, Benn, PA, Borgida AF, Rodis, JF, Campbell WA, Vintzileos AM: Efficacy of screening for fetal Down syndrome in the U.S. from 1974 to 1997. Obstet Gynecol 96:979-985, 2000

13. Benn PA, Craffey A, Horne D, Ramsdell L, Rodis JF: Elevated maternal serum alpha fetoprotein with low unconjugated estriol and the risk for lethal perinatal outcome. J Matern Fetal Med 9:165-169, 2000

14. Benn PA, Rodis JF, Beazoglou T. Cost-effectiveness of estimating gestational age by ultrasound in Down syndrome. Obstet Gynecol 94:29-33, 1999

15. Benn PA, Leo MV, Rodis JF, Beazoglou T, Collin R, Horne D. Maternal serum screening for fetal trisomy 18: a comparison of fixed cut-off patient specific risk protocols. Obstet Gynecol 93:707-711, 1999

16. Rodis JF. Parvovirus infection. Clin Obstet Gynecol 42:107-120, 1999

17. Rodis JF, Arky L, Egan JFX, Borgida AF, Leo, MV, Campbell WA: Comprehensive fetal ultrasound growth measurements in triplet gestations. Am J Obstet Gynecol 181:1128-1132, 1999

18. Feldman DM, Borgida AF, Sauer F, Rodis JF: Rotational versus nonrotational forceps: maternal and neonatal outcomes. Am J Obstet Gynecol 181:1185-1187, 1999

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Non-peer Reviewed Publications

1. Rodis JF: Spring is parvovirus time: how to counsel your patients. Ask the Perinatologist. Sarasota Memorial Hospital, Spring 1994.

2. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical and umbilical cord gases. Am J Obstet Gynecol 166:1589, 1992 (Reply to the Editor).

3. Rodis JF, Vintzileos AM: Scanning to diagnose congenital anomalies. Contemp Obstet Gynecol 36:45-54, 1991

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5. Rodis JF, Vintzileos AM: A sound way to diagnose congenital anomalies. Contemp Obstet Gynecol 36:65-76, 1991

6. Rodis JF, Quinn DL, Garry W, Anderson LJ, Rosengren SS, Cartter M, Campbell WA, Vintzileos AM: Management and outcomes of pregnancies complicated by human B19 parvovirus infection. Clinical Digest Series 2:5-6, 1991.

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8. Rodis JF, Vintzileos AM: Prenatal diagnosis by ultrasound. Contemp Pediatr 8:77-94, 1991

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Chapters

1. Rodis JF: Parvovirus Infection. In: Clinical Obstetrics and Gynecology; Roy M. Pitkin, M.D. and James R. Scott, M.D., Eds., Lippincott Williams & Wilkins, Inc., Philadelphia, PA., pp 107-112. 1999

2. Rodis JF: Intraauterine Fetal Demise. In: Fetal Disorders; Editor Boris Petrikovsky, M.D., Ph.D., Wiley and Sons, New York, New York, pp 185-192, 1998

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4. Rodis JF. Multiple Gestation. In: The Physiologic Basis of Gynecologic and Obstetrics, 1st edition, Eds. Seifer, Samuels, Kniss, Williams & Wilkins, Baltimore, MD, 1998

5. Borgida AF, Rodis JF. Twin Pregnancy. In: Quilligan EJ, Zuspan FR, Eds., Current Therapy In Obstetrics and Gynecology 5th Edition. W.B. Saunders, Philadelphia, PA., pp 364-368, 1999

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8. Vintzileos AM, Campbell WA, Rodis JF: Antepartum fetal assessment by ultrasonography: The fetal biophysical profile. In: Ultrasonography in Obstetrics and Gynecology, Third Edition, Ed. Callen PW, WB Saunders, Philadelphia, 1994, pp 487-502.

9. Vintzileos AM, Campbell WA, Rodis JF: Antepartum surveillance in patients with preterm premature rupture of the membranes, In: Eds. Pitkin RM, Duff P, Clinical Obstet Gynecol, 1991, pp 779-793

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11. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile. In: Clinical Maternal-Fetal Medicine. Editors Winn HN, Hobbins JC, The Parthenon Publishing Group, New York, 2000.

12. Vintzileos AM, Campbell WA, Rodis JF: Percutaneous intrauterine fetal shunting, In: Textbook of Operative Obstetrics. Editors Iffy L, Apuzzio JJ, Vintzileos AM. McGraw-Hill, Inc., New York, 1992, pp 110-113

13. Rodis JF, Vintzileos AM: Intrauterine Fetal Death. In: Operative Obstetrics, Second Edition. Editors Iffy L, Apuzzio JJ, Vintzileos AM. McGraw-Hill, Inc., New York, 1992, pp 192-203

14. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile. In: Antepartum Fetal Assessment. Editor A. Antsaklis (Greece) (In press)

15. Vintzileos AM, Rodis JF: Growth discordancy in twins. In: Abnormal Fetal Growth, Ed. Divon MY, Elsevier Science Publishing Co., New York, 1991, pp 289-317.

16. Vintzileos AM, Campbell WA, Rodis JF: Fetal biophysical profile scoring: current status. In: Clinics in Perinatology, Ed. Manning FA, W.B. Saunders Company, 1989 pp 661-689.

17. Campbell WA, Vintzileos AM, Rodis JF, Bors-Koefoed R, Nochimson DJ: The use of beta-blocking agents to treat hypertension during pregnancy. In: Perinatal Pharmacology, Ed. Petrie RH, Oradell, New Jersey, Medical Economics Co. Inc., 1989, pp 151-162.

Invited Regional and National Lectures:

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". New Orleans, LA May, 1998

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". Philadelphia, PA May,1999

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – "Viral Infections in Pregnancy: Cytomegaolvirus, Parvovirus and Varicella". San Francisco,CA May, 2000

Invited lecturer for the "71st Annual Meeting of the New England Obstetrical & Gynecological Society, Topic – " Shoulder Dystocia", October 20, 1999

Invited lecturer for the "14th Annual: A Day with the Perinatologists – Perspectives in Practice", Sponsored by Creighton University School of Medicine, Omaha, Nebraska. October 22-23, 1999

Invited Lecturer for Ultrasound Symposium, St. Francis Hospital and Medical Center, Topic: Role of Ultrasound Multiple Gestations. Farmington, CT April 8, 2000

Invited Lecturer for the New Jersey Maternal Fetal Medicine Society, New Brunswick, NJ. Topic: Parvovirus Infection in Pregnancy. December 2000

Invited lecturer for Annual Clinical Meetings of the American College of Obstetricians and Gynecologists. Topic – Fetal Death: Diagnosis, Evaluation and Management. Chicago, IL May, 2001

Invited Lecturer at the 27th Annual Sanford Cole MD Memorial OBGYN Symposium, Miami, Florida. Late Preterm & Early Term Births: Reducing Elective Deliveries before 39 Weeks. January 25, 2013.

Abstracts

1. Feldman DM, Trymbulak W, Sanders MM, Rodis JF, Borgida AF: Clinical implications of velamentous cord insertion in triplet gestations. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

2. Egan JFX, Rodis JF, Feldman DM, Barsoom M, DeRoche M, Borgida AF: Does the Kessler Index reflect trends of Down syndrome livebirths in the U.S.? Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

3. Borgida AF, Dixon A, Feldman DM, Rodis JF, Egan, JFX: Recurrence rate of preterm premature rupture of membranes. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

4. Rodis JF, Feldman DM, Barsoom, M, Herndon A, McKenna P: Antenatal hydronephrosis is a sign of neonatal vesicoureteral reflux. Society for Maternal-Fetal Medicine Annual Meeting, Reno, Nevada, February 5-10, 2001 (Poster Presentation)

5. Rodis JF, Feldman DM, Arky L, Campbell WA, Borgida AF: Normal values of laboratory Tests used in the evaluation of preeclampsia in triplet gestations. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

6. Rodis JF, Feldman DM, Arky L, Campbell WA , Borgida AF: Laboratory evaluation for preeclampsia in triplet pregnancies. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

7. Ling PY, Kong E, Borgida AF, Rodis JF, Egan JFX: Outcome of fetuses with echogenic bowel detected by second trimester ultrasound in a non-referral population. International Society of Perinatal Obstetricians Annual Meeting, Miami, FL, February 2000 (Oral presentation)

8. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX : Outcome of pregnancies complicated by ruptured membranes after genetic amniocentesis. Society for Maternal-Fetal Medicine Annual Meeting, Miami, FL., February 2000 (Poster presentation)

9. Borgida AF, Mills AA, Feldman DM, Rodis JF, Egan JFX: Outcome of pregnancies complicated by second trimester preterm premature rupture of membranes. Society for Maternal-Fetal Medicine Annual Meeting, Miami, FL., February 2000 (Poster presentation)

10. Benn P, Craffey A, Horne D, Ramsdell L, Rodis JF: Elevated maternal serum alpha fetoprotein with low unconjugated estriol and the risk for lethal perinatal outcome. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999 (Poster presentation)

11. Rodis JF, Arky L, Borgida AF, Egan JFX, Campbell WA: Discordance in sonographically determined estimated fetal weights and birth weights in triplet pregnancies across gestational age.

Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999 (Poster presentation)

12. Rodis JF, Arky L, Borgida AF, Egan JFX, Campbell WA: Comprehensive fetal ultrasound growth measurements in triplet gestations. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

13. Benn P, Leo MV, Beazoglou T, Rodis JF: Selecting an optimal strategy for second trimester trisomy 18 screening. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

14. Feldman DM, Borgida AF, Sauer F, Rodis JF: Rotational versus Non-rotational Forceps: Maternal and Neonatal Outcome. Society for Maternal-Fetal Medicine Annual Meeting, San Francisco, CA., January 1999. (Poster presentation)

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16. Klein S and Rodis JF - Devoting time to colposcopy: teaching residents what they need to know. 1998 CREOG/APGO Meeting, Orlando, FL, March 4-7, 1998 (Poster presentation)

17. Odibo AO, Campbell WA, Feldman D, Leo MV, Borgida AF, Rodis JF: Resolution of human parvovirus-induced hydrops after intrauterine transfusion. American Institute of Ultrasound in Medicine Annual Meeting, Boston, MA. March 22-25, 1998 (Oral presentation)

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25. Rodis JF, Rodner C, Hansen A, Borgida A, Spivey G, and Rosengren S. Long-term outcome of children following maternal human B19 parvovirus infection. Society of Perinatal Obstetricians, Anaheim, CA., January 1997 (Oral presentation)

26. Rodis JF, McIlveen P, Egan JFX, Borgida AF, Turner GW and Campbell WA. Monoamniotic twins: improved perinatal survival with accurate prenatal diagnosis and antenatal fetal surveillance. Society of Perinatal Obstetricians, Anaheim, CA., January 1997 (Poster presentation)

27. Benn PA, Borgida AF, Horne D, Briganti S, and Rodis JF. Maternal serum screening efficiency using ultrasound dating versus LMP dating. Society of Perinatal Obstetricians, Anaheim, CA., January 1997. (Poster presentation)

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29. Mihalek JJ, Borgida AF, Gotschall D, Rodis JF. Incidence of prolonged bleeding time and its association to other routine laboratory tests. American College of Obstetricians and Gynecologists, Denver CO., May 1996. (Poster presentation)

30. Karak PK, Borgida AF, Brown SL, Rodis JF, Erkmen Z, Henken ML. Polyhydramnios: a pictoral display of associated fetal structural anomalies. American Roentgen Ray Society, San Diego, May 1996. (Poster presentation)

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32. Bork MD, Egan JFX, Cusick W, Borgida A, Hardardottir H, Rodis JF, Campbell WA: Iliac wing angle as a marker for trisomy 21 in second trimester fetuses. American Institute of Ultrasound, New York City, March, 1996. (Oral presentation)

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56. Cusick W, Ciarleglio L, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for both open neural rube defects and down syndrome. American College Obstetricians and Gynecologists, Orlando, May, 1994

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67. Cusick W, Vintzileos AM, Antsaklis A, Varvarigos I, Tassis S, Rodis JF: The use of oxytocin during labor and cord blood gas values. New England Perinatal Society, February, 1993. (Oral presentation)

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132. Rodis JF, Hovick TJ, Quinn DL, Vintzileos AM, Campbell WA, Shulman-Rosengren S, Tattersall P: Human parvovirus infection in pregnancy. New England Perinatal Society Annual Meeting, February, 1988.

133. Vintzileos AM, Campbell WA, Rodis JF, Bors-Koefoed R, Nochimson DJ: Fetal weight estimation formulas using head, abdomen, femur and thigh circumference measurements. Society of Perinatal Obstetricians (SPO), February, 1987.

# David M. Bittner, CPA, MBA, FHFMA

**20 Nottingham Blvd.**
**Unionville, CT 06085**
**Phone: (860) 519-9670 · Email:davidbittner1999@gmail.com**


## PROFESSIONAL SUMMARY

Primary Focus: long-range strategic financial planning focusing on building balance sheet strength; improving the consistency and timeliness of financial information; maximizing the System's inherent strength to improve contracting leverage, purchasing power, balance sheet reserves for program/facility development, maintaining external relationships with creditors, improving access to capital, and development of staff.

### PROFESSIONAL EXPERIENCE

7/12 – present **Saint Francis Care / Saint Francis Hospital and Medical Center,** Hartford, CT
An integrated health delivery system, including 617-bed Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital, an independent rehabilitation hospital. Other system affiliates include a specialist and primary care physician group, behavioral health center, and urgent care and other access centers. The Medical Center discharges over 32,000 inpatients and treats over 500,000 outpatients annually.

**SENIOR VP AND CHIEF FINANCIAL OFFICER** **December 2014**
Responsible for daily financial operations, revenue cycle, supply chain, budgeting, cost accounting, and treasury functions.

**SENIOR VICE PRESIDENT OF FINANCE** **February 2014**
Responsible for daily financial operations, budgeting, cost accounting, and treasury functions.

- Successfully negotiated additional reimbursement of over $10 million over two years for the Hospital and Medical Center
- Identified and achieved cost savings of the state provider tax, resulting in additional net income to the health system of over $2 million annually
- Participate in Connecticut Hospital Association's committee on hospital finance and subcommittee on all-payor reimbursement diagnosis related group (ARP-DRG), which assisted the state's transition to modernize its reimbursement.
- Successfully negotiated a $0.5 million reduction in pharmacy overpayments
- Started the Health System's Investment Committee

**VICE PRESIDENT OF FINANCE** **July 2012**
Responsible for daily financial operations, budgeting, cost accounting, and treasury functions.

- Led the refinancing of $213 million of tax-exempt bonds into private placement debt in collaboration with seven different lending institutions
- Established service line reporting structures to educate physician and executive directors on financial and operational performance.
- Oversee the annual financial statement audit for the health system

8/07 – 7/12 **Memorial Health System,** Springfield, IL

An integrated health delivery system, including 500-bed Memorial Medical Center, Abraham Lincoln Memorial and Taylorville Memorial Hospitals, 25-bed Critical Access hospitals. Other system affiliates include home services and hospice, primary care physician group, mental health centers, urgent care centers, and property management. Annual net operating revenues were $736 million, generating a 2.6% operating margin in FY 2011(5.6% operating margin in FY 2010). The Medical Center discharges over 25,700 inpatients and treats over 490,000 outpatients annually.

**DIRECTOR OF FINANCE & GENERAL ACCOUNTING**

Responsible for daily financial operations, budgeting, cost accounting, charge description master, property management, treasury functions, and finance information services.

- In FY2012, collaborated with the CFO and Investment Committee to develop a $90 million new money financing plan to provide funds for two new medical office building projects; maintained A+/A1 category credit ratings by S&P and Moody's credit rating agencies.
- In FY2012, collaborated with the COO and his VP team to develop and implement monthly flexible budget to actual reporting, increasing the accountability and involvement of operational leaders in their departments' financial performance.
- Participated with the Investment Committee to review and monitor investment portfolios of over $450 million, which have outperformed the benchmark by over 27 basis points and 190 basis points for the Medical Center investments and Health System Pension investments, respectively.
- Participated in several cost savings initiative teams to reduce operating expenses, increase revenue, and develop financial reporting metrics, which led to a 2% increase in productivity (or approximately $3.2 million in salary costs) and a 20% (or $400,000) reduction in overtime.
- Led various multi-disciplinary Lean / Six Sigma teams within the supply chain, materials management, and the revenue cycle, reducing annual freight costs by over $100,000 and decreasing bad debt expense of the primary care physician group by over 50%.
- In FY 2009, collaborated with the CFO and operational leaders to complete a $150 million financing plan that issued tax-exempt bonds for use by the Medical Center and both Critical Access Hospitals; developed and implemented a credit rating strategy that secured an A+/A1 category rating from S&P and Moody's credit rating agencies.

**Ernst & Young, Kansas City, MO** **June 2005 – August 2007**

**Manager, Assurance and Advisory Services**

Ernst & Young is a global leader in assurance, tax, transaction and advisory services. Worldwide, E&Y employs over 152,000 people.

Responsible for the supervision of audits of not-for-profit hospitals and health systems with annual gross revenues ranging from $100 million to over $4 billion, participated in audit committee and board of director meetings, counseled younger staff in career development, including training of new staff and seniors, managed several teams and projects simultaneously, and participated in health care tax-exempt bond issuances and other health care consulting engagements.

**BKD, LLP, Kansas City, MO** **July 1999 – June 2005**

**Manager, Assurance and Advisory Services**

BKD, LLP is a top ten CPA and advisory firm that operates 30 offices in the Midwest. BKD employs over 2,000 professionals.

Responsible for the supervision of audits of not-for-profit hospitals and health systems with annual gross revenues ranging from $25 million to over $500 million, presented audit reports and management letters to finance committees and board of directors' meetings, supervised, trained, and reviewed the work of staff accountants, and mentored several staff accountants to establish career goals.

## EDUCATION

Bachelor of Science, 1999, Truman State University

Master of Business Administration, 2009, Benedictine University

## CERTIFICATIONS

- Certified Public Accountant Exam (passed on first attempt)
- Six Sigma Green Belt Certification
- Certified Healthcare Financial Professional

## PROFESSIONAL AND CIVIC AFFILIATIONS

- President of Lincoln Land Drug Awareness Resistance Education (DARE)
  - 2007-2010
- Treasurer and Board Member of Ronald McDonald House Charity of Central Illinois
  - 2011 - 2012
- Fellow of Healthcare Financial Management Association
  - 2011 – Current
  - Treasurer, Board Member, and Sponsorship Chair of McMahon HFMA chapter
- Adjunct Accounting Faculty at the University of Illinois at Springfield
  - 2010 – 2012
- Finance Committee Member of Food Share
  - 2012 - Current

# RICHARD J. GILFILLAN, MD, MBA

**Professional Accomplishments**

**Trinity Health** **November 2013 – Present**

**President & Chief Executive Officer**

Trinity Health is the second largest Catholic health system in the nation and fourth largest health system overall in the U.S. and operates 86 acute care hospitals, 44 home care agencies, 14 PACE centers, 70 other continuing care facilities in 20 states. Employs nearly 87,000 people including 3,300 employed physicians and 21,600 affiliated physicians. Trinity Health reported $13.6 billion in net revenues in FY2014. The ministry was formed in May 2013 with the coming together of Trinity Health and Catholic Health East. Trinity Health is sponsored by Catholic Health Ministries, a governance entity established by the Catholic Church to oversee the healing ministry and Catholic identity of Trinity Health.

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**Centers for Medicare and Medicaid Services** **August 2010 – July 2013**

**Acting Director and Director**
**Center for Medicare and Medicaid Innovation** **September 2010 – July 2013**

Directed the development and operations of this new Center within CMS charged with identifying, testing and spreading new service delivery and payment models that reduce program expenditures while improving the quality of care for Medicare, Medicaid and CHIP beneficiaries

Accomplishments:

- Created initial strategic and operating plan and obtained first year funding
- Created effective leadership team and directed the hiring of 150 new team members
- Merged the Office of Research, Development and Information with 80 staff members into the Center
- Directed the design of key Center operational activities and processes
- Directed and participated in national campaign to introduce the Center's role and approach
- Directed the development and implementation of new CMS model initiatives including Pioneer ACOs, Comprehensive Primary Care, Bundled Payment for Care Improvement, Partnership for Patients, End Stage Renal Disease, Innovation Awards Rounds 1 and 2, State Innovation Models, and Independence at Home, that engaged over 50,000 providers caring for more than 2 million Medicare and Medicaid beneficiaries
- Participated in development of CMS ACO Shared Savings and Dual Eligibles Initiatives
- Established effective working relationships with key partners across the Administration
- Represented CMS in Congressional meetings including testifying before the Senate Finance Committee

**Director**

**Performance-based Payment Policy Staff** **August 2010 – October 2010**

Directed the staff responsible for establishing regulations for the Medicare Shared Savings Accountable Care Organization (ACO) Program, the Hospital Value Based Purchasing initiative, the Physician Value Modifier initiative, and other performance-based payment programs. After 8 weeks in this position was asked by the Administrator to assume the position of Acting Director of the Innovation Center.

Accomplishments:

- Oversaw initial development of Shared Savings ACO Regulation
- Developed proposed Quality performance measurement system for ACO Regulation
- Represented CMS in more than 30 meetings with outside parties
- Built relationships with key partners across CMS
- Developed management team and rapidly hired additional staff

**Geisinger Health System, Danville Pa.** **August 2005 – July2010**

**Consultant, Washington DC** **July 2009 – July 2010**
**Geisinger Consulting Services**

Provided consulting services to health care systems and payer organizations regarding the design and implementation of alternative care systems, such as Accountable Care Organizations and Patient Centered Medical Homes

Accomplishments:
- Developed an ACO model for the leading national ACO Collaborative
- Participated in marketing and recruitment campaign for ACO Collaborative that led to more than 60 participating institutions
- Designed a capabilities assessment tool that allows health systems to identify change priorities for creating ACOs
- Led a consultant team supporting client in implementing the Collaborative
- Developed strategic approach for a large health system change initiative
- Designed a series of guidebooks for health systems to use to plan transformation to accountable care
- Developed plan for a large labor union fund to significantly reduce their medical expenditures
- Provided input to Obama Administration staff and Members of Congress on healthcare reform

**President & CEO Geisinger Health Plan** **July 2005 – June 2009**
**EVP Insurance Operations Geisinger Health System**

Had P & L responsibility for the $1 Billion Insurance Operations of this Integrated Health System and participated on the Executive Leadership Team that oversaw System operations.

Accomplishments:
- Created a well integrated management team that produced outstanding results for 4 years including:
    - Growing membership by 25%
    - Significantly exceeding financial goals for four years

- Improving Quality improvement results that raised Plan's national ranking from 33rd to top 10 for 3 years.
- Helped to design ProvenCare, an innovative care redesign/bundled payment model for specialty care
- Helped to design Proven Health Navigator, an innovative care redesign and payment model for primary care
- Expanded Plan service area to double market size
- Improved the relationship between Health Plan and System Clinical Leadership to create a partnership that enabled our efforts to build innovative care and payment models
- Achieved Outstanding Accreditation from the National Committee for Quality Assurance (NCQA)

**Coventry Health Care, Bethesda, MD** **2001 - 2005**

**Senior Vice President National Network Management**

Responsible for the Network Contracting and Medical Cost Management operations for this $3 billion national managed care organization.

Accomplishments:
- Oversaw National Contracting team responsible for contracts with 5,000 hospitals and 600,000 physicians in 50 states
- Created corporate wide Medical Cost Management process that improved medical cost trend
- Developed an innovative Primary Care delivery and reimbursement model with independent physicians in three markets
- Developed new Fraud, Abuse and Claims Recovery programs

**Independence Blue Cross, Philadelphia, Pa** **1989 - 2000**

**General Manager**
**AmeriHealth HMO & Insurance Company, Mount Laurel, NJ** **1995 – 2000**

Profit and Loss responsibility, including start-up, for a new managed care subsidiary

Accomplishments:
- Profitably grew the business over 5 years to $300 Million Revenue base and 300,000 Commercial, Medicare and Medicaid members
- Built successful leadership team and grew staff from 15 to over 150
- Instituted quality improvement programs that led to # 1 State ranking for three years
- Oversaw the successful implementation of a new enterprise wide computer operating system.
- Directed the development of a new corporate medical informatics system

**Chief Medical Officer and Senior Vice President**
**Independence Blue Cross and Subsidiaries, Philadelphia, PA** **1992-1995**

Oversaw the medical management activities for all subsidiaries of this $3 Billion Blue Cross plan with approximately 3 million members

Accomplishments:
- Merged the medical management function of three HMO's into one 300 person staff
- Created state of the art quality, utilization and medical cost management functions
- Achieved full accreditation from the National Committee for Quality Assurance

- Developed innovative, first in the nation contact capitation program for cardiology care

**Medical Director and Senior Vice President**
**Keystone Health Plan East** **1989 – 1995**

Oversaw the medical and network management activities for this start-up HMO

Accomplishments:
- Established new Medical Management and Provider Relations Teams
- Helped directed expansion of the provider network to include 8,000 physicians and 60 hospitals
- Developed innovative Disease Management Programs
- Instituted an innovative radiology capitation program that decreased costs by 30%
- Developed one of the first in the nation commercial Resource Based Relative Value System (RBRVS) physician fee schedules that decreased costs by approximately 20%
- Achieved full NCQA accreditation

**New Jersey Blue Cross and Shield** **1985 – 1989**

**Medical Director and Primary Care Physician**
**Medigroup Central HMO Trenton, NJ**

Created network and medical management functions and practiced adult and pediatric primary care medicine half-time in inner city Trenton for a staff/network model HMO

Accomplishments:
- Established a new Independent Physician Association (IPA) division and management team
- Built provider network that included 15 hospitals and 500 physicians
- Led a reengineering initiative in staff primary care sites to improve waiting times
- Improved customer satisfaction in the staff model
- Established innovative mental health carve-out contract that improved care and lowered costs

**Winchendon Community Health Center, Winchendon Ma** **1980 – 1985**

**Medical Director and Family Practitioner**

Practiced full time adult, pediatric and obstetrical care and was the medical director in a small, rural poor community in Central Massachusetts.

Accomplishments:
- Built a new family medicine group practice of three physicians
- Led the conversion of a 28 bed town hospital into a Community Health Center
- Served as Secretary and Treasurer of the medical staff at parent hospital
- Established academic relationship with Medical School

**Georgetown University Community Health Plan, Washington, DC** **1979 – 1980**

**Primary Care Family Physician**

## Education

| | |
|---|---|
| The Wharton School of the University of Pennsylvania, MBA | **1992** |
| Hennepin County Medical Center, Family Practice Residency | **1979** |
| Georgetown University School of Medicine School, MD | **1976** |

Georgetown University School of Foreign Service, BSFS **1971**

**Board Activities:**

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**Alliance of Community Health Plans Board of Directors** **2007 – 2009**
Director on the Board of this industry Association of not-for-profit managed care organizations that includes Kaiser, Health Partners and 11 other Health Plans

**Geisinger Insurance Operations Boards of Directors** **2005 - 2009**
Director on the Boards of the three companies that make up Geisinger Insurance Operations

**Geisinger Health Science Foundation Board of Directors** **2005 – 2009**
Participated in quarterly meetings and provided updates on the performance of the Insurance Operations

**New Jersey State Chamber of Commerce Board of Directors** **1996 - 2000**
Director on a Board made up of CEO's and senior executives from large New Jersey companies including Prudential, Bell Atlantic, AT&T and Johnson & Johnson

**AmeriHealth New Jersey Board of Directors** **1995 - 2000**
Made quarterly presentations to HMO Board regarding overall strategy and results

**Vice Chairman, Princeton Regional Health Commission** **1992 – 1995**
Participated in and chaired monthly public meetings of the Commission overseeing public health for Princeton, NJ

**Keystone Health Plan East Board of Directors** **1989 – 1995**
Presented medical and quality management reports to a Board that included the IBC CEO and external directors representing large community employers

**Medigroup Central Board of Directors** **1985 – 1989**
Director on the Board overseeing the HMO subsidiary of New Jersey Blue Cross

**Winchendon Hospital Board of Directors** **1980 – 1985**
Director and member of the Hospital Executive Committee that negotiated a merger with another community hospital.

**BENJAMIN R. CARTER, CPA, FHFMA**

**CAREER OBJECTIVE** To be a CEO and Regional Leader of a large Diversified and Integrated Health Care Delivery System

**EDUCATION:**

MBA, 1992; University of Michigan (Magna Cum Laude)
BBA, 1980; University of Michigan (Magna Cum Laude)

**WORK EXPERIENCE:**

May, 2013 – Present

***Trinity Health; Livonia, MI***
***Executive Vice President and CFO/Treasurer***

Responsible for the System strategic and financial operation of the 21 state Trinity Health System. Trinity Health is the second largest Catholic Health Care System in the country with total net revenues exceeding $13.5 Billion, including over 82 hospitals, 89 continuing care facilities, the largest not for profit home health agency in the country, and over 3100 employed physicians.

Responsibilities include all aspects of financial management and reporting, strategic and financial planning, capital planning, budget development, revenue cycle management, third party contracting and strategic payor alliances. Responsibilities also include Treasury services and asset management for $16 Billion of investable assets, debt management for $5 Billion of long term debt, investor relations, and Insurance and Risk Management Services.

Trinity is AA rated organization with a consistent record of strong operating and non-operating financial results.

March, 2010 – May, 2013

***Trinity Health; Novi, MI***
***Senior Vice President and Chief Financial Officer***

Responsible for the system financial operations of the 10 state, $9.0 Billion Trinity Health organization. Prior to merging with Catholic Health East (CHE), Trinity Health was the fourth largest Catholic Health Care system in the country, comprising 49 hospitals, 32 long term care facilities, and a 6 State home health agency. Responsibilities include all aspects of financial management and reporting, strategic and financial planning, capital planning, budget development, revenue cycle management and third party contracting.

Trinity Health was a AA rated organization with superior operating and non-operating performance, exceeding peer group averages.

May, 2005 – March, 2010

***Detroit Medical Center; Detroit, MI***

***Executive Vice President and Chief Operating Officer***
Responsible for the system operations of the eight hospitals and related outpatient facilities that comprise the $2 Billion Detroit Medical Center. Responsibilities include oversight of all system support services including Retail Pharmacy, Managed Care Contracting and Operations, University Laboratory and Commercial Operations, Physician Recruitment and Office Practice Management, Information Services, System wide Security, Professional Sports Medicine program, Purchasing and Procurement, and Graduate Medical Education and Centralized Credentialing.

Key accomplishments include turn around of the organization from $100 million annual loses in 2002 and 2003, to six straight years of profitability, including 2009 expected operating income of $40 million. Led key growth, cost reduction, and profit initiatives in multiple service lines contributing to successful turnaround.

1999 – May, 2005

***Oakwood Healthcare, Inc.; Dearborn, MI***
*Chief Financial Officer and Executive Vice President*
Responsible for all financial operations of the $860 million healthcare system including: Treasury Management, General Accounting (including accounts payable and payroll), budget and Decision Support, Internal Audit, Legal Services and Information Systems. As a member of the Executive Council, responsibilities include setting corporate policy and overseeing their successful implementation and maintenance. Successfully managed the implementation of a 3-year Financial Viability Plan, restoring the financial performance of the System to historically high levels. In 2004, the System achieved a total margin of $36 million, a 2.0% operating margin, and maintained an "A" rating with a stable outlook.

1997 – May 2005

***Oakwood Enterprises, Inc.; Dearborn, MI***
***President and Executive Vice President, Oakwood Healthcare, Inc.***
Responsible for the development and operation of the Oakwood Healthcare, Inc. subsidiary which operates for profit health related businesses and creates joint ventures for the system, including home services and real estate development. Have held a number of executive posts within Oakwood Healthcare, Inc., including Interim Chief Financial Officer and Interim Chief Operating Officer. Member of the Oakwood Healthcare, Inc. Executive Council, which sets policy system-wide, and is responsible for strategic planning and deployment.

1995 – April, 1997

***Oakwood Healthcare System; Dearborn, MI***
***Senior Vice President, Support and Related Services***
Responsible for Human Resources, Risk Management and Legal Affairs, Information Services, Quality Assurance, Operations Analysis, Materials Management, Architecture and Construction, and Foundations (since June, 1996) for the Corporation. Total capital and operating budgets in excess of $150 million per year. Reported directly to the Executive Vice President and Chief Operating Officer. Member of the System-wide Transition Team charged with designing the year 2000 Integrated Delivery System. Administrative Coordinator for Facilities/Planning/Technology Assessment Board Committee. Also a member of the Quality Assessment and Improvement Board and continuous Quality Improvement Steering Committee.

1991 – 1994

***Oakwood United Hospitals, Inc.; Dearborn, MI***
***Senior Vice President and Controller***
Responsible for the financial management of a five-hospital system and nursing home, with an annual budget in excess of $200 million. Responsibilities included Treasury Management, budgeting, accounting and reimbursement, third-party contracting, and all revenue cycle functions, including Medical Records, Utilization Review, Quality Assurance, and Patient Accounting. Reported directly to the Chief Executive Officer. Also a member of Oakwood Health Services Operations Committee and Continuous Quality Improvement Steering Committee.

1989 – 1990

***Oakwood United Hospitals, Inc.; Dearborn, MI***
***Vice President and Controller***
Responsible for the management of the financial operations of a four-hospital system. Responsibilities included Treasury Management, budgeting, financial analysis, accounting and reimbursement, third-party contracting, and all revenue cycle functions, including Medical Records, Utilization Review, Quality Assurance, and Patient Accounting. Reported directly to the Chief Executive Officer, and worked closely with the Chief Operating Officer on management issues.

1988 – 1989

***Oakwood Hospital Corporation; Dearborn, MI***
***Vice President of Accounting and Reimbursement***
Responsible for the preparation of financial statements of the Hospital and related companies. Responsibilities included management of all reimbursement functions and negotiations of third-party contracts. Also responsible for all not-for-profit and for-profit tax filings.

1986 – 1988

***Plante & Moran CPAs; Southfield, MI***
***Director of Healthcare Services, Southeastern Michigan***
Responsible for the management of audit and consulting projects for the firm's healthcare clients, including hospitals, nursing homes, and home health agencies.

1980 – 1986

***Plante & Moran CPAs; Southfield, MI***
***Audit Staff and Associate***
Member of the audit staff responsible for completing audits of manufacturing and municipal clients.

**BOARDS: (Past examples)**

- DMCIC
- DMC Care Express
- Michigan Mobile Imaging
- CareTech Solutions, Inc.
- Oakwood Assurance
- HealthLink
- Invest Michigan Advisory Board

**AFFILIATIONS:**

Member:

- American Institute of Certified Public Accountants
- Michigan Association of Certified Public Accountants
  - Chair, Healthcare Committee; 1993 – 1995
  - Vice Chair, Healthcare Committee; 1991 – 1993
- Healthcare Financial Management Association
  - Board Member 1989 – 1993
  - Treasurer 1993 – 1994
  - Secretary 1994 – 1995
  - President-Elect 1995 – 1996
  - President 1996 – 1997
- Boys Hope of Detroit, Board Member; Treasurer and Finance Committee Member
- Health Alliance Plan, Board Member – 1985 – 1988
- Michigan Health Management Information Systems
  - Member, Executive Steering Committee
- Michigan Health and Hospital Association
  - Member, Payment Practices Committee
  - Member, Data Task Force
- Greater Detroit Area Health Council
  - Member, Steering Committee; National Health Information Technology Lab
- Joe Dumars Foundation; Treasurer

**AWARDS:**

HFMA (Healthcare Financial Management Association)

- Chapter Achievement Award of Excellence
- Follmer Bronze Merit Award
- Reeves Silver Merit Award
- Muncie Gold Merit Award
- Certified Fellow

Phi Beta Kappa
Beta Alpha Psi
Licensed Nursing Home Administrator

**PERSONAL:**

Married; four children
Enjoy golf, running, basketball and reading
Private pilot; Certified Flight Instructor, Instrument Rated

# James Richard O'Connell

**SUMMARY OF QUALIFICATIONS**

Forty years of progressive healthcare experience with executive level leadership in both corporate and hospital facilities ranging in bed size from 174 to 522. Geographic locations include Oklahoma, Texas, Florida and Colorado. Major strengths in the development of quality; cost efficient programs; team building; medical staff relations; community relationships and board development and involvement. Have had experience in not for profit, faith based and for profit healthcare facilities.

**STRENGTHS**

Business turnaround and culture change, program development and strategic positioning, physician / hospital relationship development, patient advocacy, associate engagement and community / board involvement.

**PROFESSIONAL EXPERIENCE**

**Trinity Health**

**Executive Vice President – East Group**
**July 2014 to present**

**Executive Vice President-West/Midwest Group**
**April 2013 to July 2014**

**Executive Vice President & Chief Operating Officer**
**October 2008 to April 2013**

TRINITY HEALTH
20555 Victor Parkway
Livonia, Michigan

**Centura Health**

**Executive, Development and Community Relations**
**Feb 2008 to August 2008**

PENROSE-ST. FRANCIS HEALTH SERVICES –CENTURA HEALTHCARE
2222 North Nevada Avenue
Colorado Springs, Colorado

After my resignation as CEO of Penrose St Francis Health Systems, Centura requested me to stay on in the position of Executive Development and Community Relations. Responsibilities include representing the hospital on local community boards. Maintaining the positive image that the team established for the hospital and Centura Health in the community. Additionally, led fundraising efforts and managed the construction of a 460,000 foot Saint Francis Medical Center, completed on time and on budget, and opened 8/8/08. Through the development of this 21st century hospital, we created a sense of excitement in the community to gain a cross section of support for this new facility. Continue to foster relationships with community members and leaders to lay the foundation for the success of my replacement.

**Centura Health**

**President and Chief Executive Officer**
**May 1999 to Feb 2008**

PENROSE-ST. FRANCIS HEALTH SERVICES (522 licensed beds)
2222 North Nevada Avenue
Colorado Springs, Colorado

Led this 522 bed, 3 hospital system to world class recognition, financial and quality performance for over nine years.

- Financial Turnaround: From 1999 operating loss of <$8.5> million, to operating income of $53.6 million in 2007
- National Recognition Solucient's 100 Top Hospitals five times
- U.S. News and World Report Best Systems in the Country 2006 and 2007
- HealthGrades Distinguished Award for Clinical Excellence five years running
- HealthGrades America's 50 Best Award Winner 2007
- Three major construction programs all on time and on budget:
  - Audubon Medical Campus and Surgery Center - $23 million
  - Penrose Main Bed Tower and Medical Office Building - $ 67 million
  - St. Francis Medical Center new 465,000 sq. ft. facility (scheduled to open 8/8/08) - $207 million
- Community and Board Relationships: developed positive community relationships through board involvement, public speaking and community program development
- Physician Engagement: Enhanced physician relations through numerous programs, services and joint venture development all focused on improved quality and patient care
- Associate satisfaction improvement in every annual survey
- Patient satisfaction improvement received consumer choice award last two years
- Recognized as Center of Excellence by Payers in both cardiology and bariatrics

Columbia/HCA **President and Chief Executive Officer**
**1995 to April 1999**

LUCERNE MEDICAL CENTER (267 licensed beds)
818 Main Lane
Orlando, Florida

- Made substantial impact on the public's awareness and positive perception through continuous community involvement and outreach programs
- Gallup Surveys indicate a continuous increase in-patient, physician and associate satisfaction
- Received Key to the City from the Mayor of Orlando for our active, ongoing partnership in community health
- Developed and received approval from the City of Orlando on our 10-year Facility Master Plan
- Developed active relationship in education with The University of Central Florida
- Planned and completed new expanded Emergency Room facilities to better serve the community
- Increased annual open-heart surgical volume from 176 to 400 cases within a three-year time period
- Received JCAHO Accreditation with Commendation in 1996
- Received 3-year CARF accreditation with no recommendations for our 35-bed rehabilitation facility

Columbia/HCA **President and Chief Executive Officer**
**1995 (3 months)**

COLUMBIA MEDICAL CENTER DAYTONA (214 licensed beds)
400 North Clyde Morris Boulevard
Post Office Box 9000
Daytona Beach, Florida

Responsible for JCAHO preparation and facility staffing reorganization. Columbia Medical Center Daytona subsequently received accreditation with commendation from JCAHO.

Columbia/HCA **President and Chief Executive Officer**
**1993 - 1995**

PEMBROKE PINES HOSPITAL (301 licensed beds)
2301 University Drive
Pembroke Pines, Florida

Responsible for reversing the hospital's multiple year operational deficit into a progressive profit status for 1994 -1995. Spearheaded operational improvements, new programs (neurosurgery, pediatrics, sleep lab and vascular laboratory) and joint venture / lease of facility to Local Hospital District. Hospital EBDITA increased 170% to $2.3 million prior to lease.

Columbia/HCA **Chief Operating Officer**
**1992 - 1993**

MIAMI HEART INSTITUTE (252 licensed beds)
Miami Beach, Florida

Responsible for the pre-acquisition due diligence for the merger of Miami Heart Institute and Miami Beach Community Hospital. The merged facilities had a total of 531 licensed beds. Plans were developed and executed for departmental resource consolidation. Responsible for overall hospital operations. Administrative representative for all medical staff committees.

Columbia/HCA **Chief Operating / Financial Officer**
**1991 - 1992**

MIAMI BEACH COMMUNITY HOSPITAL (273 licensed beds)
Miami Beach, Florida

Responsible for pre-acquisition and post-acquisition success for this 273-bed, full-service, acute care facility. Direct administrative responsibility for all hospital departments. Actively involved in recruitment and retention of physicians. Served as administrative representative on all medical staff committees. Responsible for successful accreditation by JCAHO and other regulatory agencies. Accountable for all financial operations of the hospital.

AMI **Corporate Director of Operations**
**1990 – 1991**

AMERICAN MEDICAL INTERNATIONAL
Dallas, Texas

Developed analytical framework for analysis of hospitals' performances. Prepared financial comparison and analysis reports. Reviewed hospitals' monthly projections against actual results. Worked closely with hospital CEO's and CFO's to identify opportunities for improvement. Reviewed hospital operating budgets for accuracy and completeness. Facilitated budget training classes for administrative staffs of all AMI hospitals. Developed capital budgeting process for all AMI facilities, including internal rate of return analysis.

AMI

**Chief Financial Officer**
**1989 - 1990**

AMI MEMORIAL HOSPITAL TAMPA (174 licensed beds)
Tampa, Florida

Responsible for all financial operations of the hospital. Maintained financial records and statistics needed by the hospital and corporate office for evaluating financial performance, satisfying audit requirements and completing governmental reports. Prepared hospital operating and capital budgets. Prepared financial forecasts for corporate office. Assisted and advised all department heads in the analysis of their department's financial results. Established and maintained the appropriate internal controls in all applicable departments.

AMI

**Chief Financial Officer**
**1987 - 1989**

AMI PARKWAY REGIONAL MEDICAL CENTER (412 licensed beds)
North Miami Beach, Florida

Responsible for all financial departments of the hospital. Responsible for the preparation of hospital operating and capital budgets. Prepared monthly financial projections for corporate office. Monitored hospital performance to ensure budgeted goals are met; analyzed and explained variances. Responsible for all contract negotiations. Responsible for the operations of two walk-in clinics and a major diagnostic imaging center. Served as administrative representative on various medical staff committees and board of directors.

AMI

**Chief Operating / Financial Officer**
**1985 - 1987**

AMI DOCTORS' MEDICAL CENTER (221 licensed beds)
Tulsa, Oklahoma

Direct administrative responsibility for various hospital support and ancillary departments. Prepared hospital operating and capital budgets. Analysis of income and expense statements. Continually monitored hospital's actual performance versus budget. Feasibility analysis for all projects and ventures. Presented financial review to the board of directors. Assisted in physician recruitment and retention, contract negotiations and joint ventures.

AMI

**Manager, Business Operations / Controller**
**1979 - 1985**

AMI DOCTORS' MEDICAL CENTER
Tulsa, Oklahoma

Supervised and coordinated the activities of managers and supervisors. Increased productivity and consistency of business related activities. Assisted chief financial officer in the preparation of monthly financial statements and hospital budgets. Responsible for all accounting functions, including accounts payable, accounts receivable, payroll and quarterly / annual reports.

AMI

**Data Processing Manager**
**1975 - 1979**

AMI DOCTORS' MEDICAL CENTER
Tulsa, Oklahoma

Responsible for converting the hospital's manual posting system to a computerized system using an IBM System 3 computer. Wrote and maintained more than 400 user programs, ranging from accounts receivable and payable systems to departmental productivity and budgeting systems.

COMMUNITY

Served on community boards including: Chamber of Commerce, Goodwill Industries, Community Health Partnership, Pikes Peak Education Foundation, El Paso County Equestrian Center, Pikes Peak Humane Society and Joint Initiatives for Families and Children. Led the initiative to create a Detox Continuum for El Paso County. Raised over $15 million in community funds for various projects including the John Zay House, a special project to build an 11 suite home for those receiving extended hospital treatment. This is a project sponsored by the Home Builders Association (HBACares) Recognized as Colorado Springs Business Citizen of the Year in 2004 for community involvement.

EDUCATION

Central State University
Edmond, Oklahoma
B.B.A. December, 1975
Major: Business Administration
Special emphasis in Accounting and Business Law

Oklahoma Baptist University
Shawnee, Oklahoma
May 1974 - May 1975
Major: Hospital Administration

REFERENCES

Available upon request

# EXHIBIT 14 a

# Population Health Management: The Intersection of Concept and Reality

CHRISTOPHER DADLEZ, FACHE

THE FEATURE ARTICLES in this issue of *Frontiers* offer different philosophies and approaches to meeting the Triple Aim of the Institute for Healthcare Improvement. Zenty, Bieber, and Hammack document a local and granular means of creating targeted accountable care organizations (ACOs) to make Triple Aim inroads toward ensuring the health of the discrete populations. Their "build on success" approach offers practical insights on developing mission, governance, and analytics to guide the creation of clinically oriented population health programs, in contrast to the "total population health" ambitions of Kindig and Isham.

Over the past five years, Saint Francis *Care* has been working on many of the same issues and initiatives mentioned in both of the feature articles, from population health management to clinical integration to aligning clinical and social services to developing accountable care models for several payers, including our own hospital, Medicare, and private insurers. Along the way, we have encountered the intersection of concept and reality and forged a path forward.

## SAINT FRANCIS *Care*

Saint Francis *Care,* an integrated healthcare delivery system in central Connecticut, is the largest independent Catholic healthcare provider in New England. Our services cover the spectrum of patient needs, including community-based preventive and primary care, specialty care, high-acuity tertiary care, and post-acute care. Many of these services are provided through partnerships, affiliations, and relationships developed with other exceptional providers. Overall, Saint Francis *Care* provides access to almost 900 affiliated physicians, three hospital campuses, 12 satellite medical offices, and a variety of community clinics.

Christopher Dadlez, FACHE, is president and CEO of Saint Francis *Care* Inc. in Hartford, Connecticut.

With 617 licensed beds and 65 bassinets, the flagship of Saint Francis *Care* is Saint Francis Hospital and Medical Center in Hartford. The hospital expanded in 2011 with the addition of the ten-story John T. O'Connell Tower, featuring a state-of-the-art surgical pavilion, dedicated space for the Connecticut Joint Replacement Institute (CJRI), and an expanded emergency department (ED) with 70 treatment areas and a rooftop helipad for the LIFESTAR helicopter. In addition to CJRI, Saint Francis offers centers of excellence in cancer care, heart and vascular disease services, rehabilitation medicine, and women and infants' services. Indeed, Saint Francis opened its 24,500-square-foot Comprehensive Women's Health Center in November 2013, a site that combines breast health, heart health, gynecologic care, and integrative medicine services for women.

Our integrated healthcare delivery system also includes the Mount Sinai Rehabilitation Hospital, Connecticut's only free-standing acute care rehabilitation hospital, which shares space on campus with our Mandell Center for Multiple Sclerosis. In addition, Johnson Memorial Medical Center signed an affiliation agreement with Saint Francis in 2012. The central structure for our ACO is Saint Francis HealthCare Partners, a 50:50 physician–hospital partnership that provides clinical integration and comprehensive administrative support to 700 physicians in more than 200 practices.

## A Vision for Value

While we have outstanding facilities, we have long recognized that a well-articulated strategy and aligned providers—not bricks and mortar—are the foundation for advancing healthcare delivery. Back in 2009, Saint Francis *Care* embarked on a unique strategic planning process with an eye toward shaping an organization that would be well positioned to thrive in a changing and uncertain healthcare environment. The core working group was small but represented a diverse mix of administrators, physicians, and board members. *The Innovator's Prescription: A Disruptive Solution for Healthcare,* by Christensen, Grossman, and Hwang (2008), was assigned reading for this group.

From this work, we generated a compelling vision: Best*Care* for a Lifetime. The focus was on delivering value for patients across the continuum of care. In other words—and this was a major shift—we explicitly emphasized the importance of what happens outside the hospital. We were setting the stage to work toward accountable care and saw innovation and a coordinated infrastructure as key drivers.

To achieve the vision of Best*Care* for a Lifetime, our strategic plan called for a new organizational structure, with ten service lines that would set their sights to include the pre-acute/preventive, hospital, and post-acute environments: Behavioral Health, Cardiovascular, CJRI, Emergency Medicine, Medicine, Oncology, Physical Medicine and Rehabilitation, Primary Care, Surgery, and Women and Infants. The work of these service lines is facilitated by robust support platforms that include Business, Clinical Services, and Facilities, as well as our award-winning Innovation + Learning Center. As we had no illusions that a service line model of care was the only key to achieving our vision, the strategic plan also called for becoming a value provider and developing a geographic presence.

By adopting the definition of *value* as outcomes that matter to patients per dollars spent, we leveraged our new organizational structure to focus on the needs of our patients and communities across the continuum of care. To support our

increased emphasis on value, two dozen physicians and executives from Saint Francis have attended Harvard Business School courses presented by professors Michael Porter and Robert Kaplan to engage directly in the latest thinking on value measurement. Armed with a common vocabulary and shared understanding, these leaders were able to reach consensus on a standard Saint Francis approach to not only defining value but also defining outcomes that matter, engaging patients, defining cost, mapping processes, and prioritizing value-oriented projects. We now have a clear mandate for value-driven design across the enterprise, with an aim to deliver value for patients, providers, and payers.

***The ACO committee structure proved to be a valuable tool in closing the knowledge gap, at least for those most actively involved.***

While focusing on value is the key to staying ahead of the curve in an accountable care world, the advent of funding based on total cost of care and annual budgets requires a coherent geographic presence. In our very competitive marketplace, we have pursued a clinically integrated network approach to avoid the pitfalls and expense of vertical integration. Our alignment strategy is based on providing as much infrastructure support in as many areas as possible, short of an outright acquisition of the practices. By providing infrastructure support, credentialing, contracting, care coordination, and information technology—as well as requiring compliance with our clinical integration approach—we were able to develop our advanced Clinical Integrated Network.

## Involving the Board and Engaging Physicians

As many population health initiatives and activities—even those focused on clinical aspects—are relatively new for most healthcare systems, it is absolutely critical to involve the board of directors and engage physicians as equal partners in the transition from volume to value. Early on in our process of developing our population health strategy, we used our annual Board and Leadership Summit to provide context and solicit guidance.

The outcome of that approach was that our board of directors endorsed the recommendation to position Saint Francis HealthCare Partners as the foundation for ACO development, again emphasizing the importance of what happens in physician offices and communities (i.e., not just the hospital). Numerous educational sessions were developed and deployed for the physician community. They were offered at several sites, and physicians were invited to attend at a site of their choice. Our initial aim was to answer as many questions as possible regarding the Affordable Care Act, ACO development, population health, physician requirements, patient engagement, and shared savings.

In terms of governance, we initially created ten ACO committees. More than 170 physicians signed up to participate, with most expressing interest in the Committee on Finance and Shared Savings. The ACO committee structure proved to be a valuable tool in closing the knowledge gap, at least for those most actively involved. After two years in operation, the ACO committees were merged with the eight physician–hospital organization committees, as there was no need for them to operate in parallel universes.

Today, we have 12 committees, all meeting regularly and generating significant physician feedback. That said, we still have a significant knowledge gap. Although our providers have all received information on ACOs and population health management,

many express confusion or a desire to gain a more thorough understanding. Accordingly, we are working to develop the form and content of appropriately tailored population health education for our providers as well as for our patients and the community.

## Accountable Care: Learning While Doing

Much like Zenty, Bieber, and Hammack, we have piloted several accountable care opportunities, all treated as disciplined experiments with the intent of refining our capabilities in preparation for assuming downside risk:

- *Employee ACO.* In an effort to both manage our own spending as a self-insured employer and create a model of what we could do for other large employers, we contracted with Saint Francis HealthCare Partners to create an employee ACO. The principles of accountable care were implemented for 6,500 members, and the combination of plan design changes, care coordination interventions, and wellness incentives yielded a tangible reduction in our cost trend experience.
- *Medicare Shared Savings Program ACO.* In January 2013, Saint Francis HealthCare Partners was awarded a Centers for Medicare & Medicaid Services (CMS) ACO contract covering 20,000 lives. As data from CMS has been fed into our claims data warehouse, we have developed new analytic competencies. In addition, we have embedded care coordinators in our large physician practices and used a public utility model to provide care coordination from a central source for our smaller practices.
- *Commercial ACOs.* Private payers quickly got up to speed with accountable care payment mechanisms. In the past year, Saint Francis HealthCare Partners entered into two commercial ACO arrangements, covering another 55,000 lives. Both of these commercial agreements have similar structures based on a total cost of care (i.e., population health management) model.
- *Bundles.* CJRI is a leading-edge program on a number of levels; for example, it offered one of the first bundled products for hip or knee replacement in the United States. These joint bundles include payment for surgeons, anesthesiologists, and the hospital. An additional postsurgical warranty rider is also available.
- *Care coordination.* Saint Francis employs a structured care coordination model, with staffing based on national norms. Covered lives are stratified by health risk, and health coaches are assigned to the highest-risk patients for interventions. Mechanisms to address gaps in care, transitions in care, ED follow-up, and discharge appointment follow-up are all part of the program.

## Population Health (Not Just Healthcare)

Operating as a Medicare Shared Savings Program ACO, building an employee ACO, working with private payers to develop new commercial ACO arrangements, offering bundles to the marketplace, and ramping up an enterprise-wide care coordination program all depend on a population health management infrastructure that continues to require significant investment in personnel and information technology. We have successfully built such an infrastructure, but we know our work is not nearly done. A focus on clinical care and clinical integration is

insufficient as we move to an environment in which healthcare providers are accountable for broadly defined health outcomes. In other words, it's not just healthcare. In the context of population health, the big picture includes behavioral and social determinants of health. The key question is whether—and how—healthcare systems can influence these determinants or integrate community and social services that can.

In highlighting the total population health approach, Kindig and Isham also shed some light on why current approaches focus on clinical health for populations. They refer to the definition of population health used by the Institute of Medicine's Roundtable on Population Health Improvement: "The health outcomes of a group of individuals, including the distribution of such outcomes within the group." Given that scope, no one should be surprised or disappointed that healthcare organizations would focus on clinical care. Not only is it their expertise, but the emphasis on outcomes seems to support a clinical approach as well. However, clinical care improvement is only part of the original concept developed by Kindig and Stoddart (2003), which offers a broader and deeper view of population health as encompassing "the definition and measurement of health outcomes and their distribution, the patterns of determinants that influence such outcomes, and the policies that influence the optimal balance of determinants."

***Early on in our process of developing our population health strategy, we used our annual Board and Leadership Summit to provide context and solicit guidance.***

It is this expanded view that animates the total population health concept offered by Kindig and Isham. Indeed, perhaps most compelling in their article is the statement that "the contribution of healthcare to health is modest—only 20 percent—a fact that many healthcare leaders may find surprising." *Stunning* may be the better word choice here, particularly because other research suggests that 20 percent might be a generous estimate. The other 80 percent of healthcare determinants are identified as health behaviors (30 percent), social and economic factors (40 percent), and physical environment (10 percent)—items outside the control of traditional healthcare delivery systems. This finding challenges the paradigm that has tipped the balance toward sick care instead of healthcare.

That many of our patients struggle with behavioral and social determinants of health is not news. But what is the extent to which healthcare organizations can and should productively partner with patients, communities, and community-based support/social services organizations to address these determinants and improve outcomes? Different healthcare organizations will have different answers to this question. At Saint Francis, we have been working hard to engage all those partners when appropriate. (We say "when appropriate" because not all patients need social services. But for those who do, these services are the rate-limiting step for some patients. In other words, if people cannot take care of their lives, they will have a hard time taking care of their health.)

We have been learning real-world lessons for more than two years as our Emergency Medicine and Primary Care service lines work with our Innovation + Learning Center and Saint Francis HealthCare Partners to improve emergency medicine–primary care coordination. Much of this work has focused attention on the relatively small number of patients who account for a disproportionately large share of ED visits. We developed a robust ED registry that helped us move from

lamenting high *utilization* to getting to know our high *utilizers*. We are now making concerted efforts to integrate clinical services, to focus on care coordination—which includes coordinating the coordinators—and to partner with community and governmental organizations in building a network of care that historically would have been considered outside the purview of a hospital, much less healthcare in general. This is a step toward the community health business model promoted by Kindig and Isham.

## Accountable Care Communities

Some of our efforts reflect a move toward an accountable care community (ACC) model that bridges clinical and community settings to address both the medical and the social needs of high-risk, high-cost, or vulnerable patients in an integrated manner consistent with the Triple Aim. In fact, we partnered with Community Solutions and the Department of Mental Health and Addiction Services in Connecticut—as well as with NuHealth, the Health and Welfare Council of Long Island (NY), and Health Leads on Long Island—to submit a proposal to CMS's Center for Medicare & Medicaid Innovation (CMMI) for developing ACCs in Hartford County and Nassau County.

*Accountable care community* is a term that was first employed by the Austen BioInnovation Institute in Akron (ABIA) to describe a multisector, community-based collaborative effort to transform healthcare in Northeast Ohio. The ABIA (2012) defines an ACC as

> *A collaborative, integrated, and measurable strategy that emphasizes shared responsibility for the health of the community, including health promotion and disease prevention, access to quality services, and healthcare delivery. . . . It builds on initiatives to encompass not only the area's medical care providers, but also the public health system and community stakeholders whose work, taken together, spans the spectrum of the determinants of health.*

The National Governors Association (2013) suggests that ACCs "take the concept of medical homes and accountable care organizations one step further by fostering collaborations borne of shared responsibility among clinical and community sector participants to reform health systems in particular localities." Kindig and Isham mention ACCs as one model with the potential for addressing total population health.

## The Integrator Role

Kindig and Isham appropriately highlight the importance of an "integrator," an organization that will pull together the various clinical and social services. Whether we like it or not, given our community presence, hospitals and healthcare organizations will be at the center of these population health dynamics. And even if we account for only 20 percent of health outcomes, we may always be expected by our communities and by business and government sectors to provide central leadership and do the population health "heavy lifting." That expectation will require that we play a role in both clinical and social initiatives. Finding the appropriate mix between the two will be a challenge for any provider. The HealthPartners example featured by Kindig and Isham and similar initiatives will be rare examples indeed unless and until payment models support this kind of work. But it is possible. As a point of reference, the actuarial analysis conducted for our CMMI proposal forecasted a reduction in Medicaid spending

that would produce shared savings sufficient to sustain the ACC program in both Hartford County and Nassau County.

The Hartford region has a highly competitive healthcare landscape, which raises another set of fundamental questions: Can total population health be achieved in a competitive clinical environment? Can the healthcare organizations work together? And how? Providers are in the midst of changing the clinical business model, but is it even more important to develop a sustainable model for integrating clinical services and social services to address the social determinants of health? As might be expected for any new endeavor, there are more questions than answers. But some answers are starting to emerge.

***Achieving alignment will require a formal yet dynamic framework to guide stakeholder engagement and shared decision making at the community level.***

For instance, Saint Francis, along with the other major hospitals in Hartford, provided funding for the City of Hartford's *Community Health Needs Assessment* report. Scheduled for publication every three years, the first edition was released in March 2012 by the city's Department of Health and Human Services. This study examines the social determinants of health—income, shelter, education, access to nutritious foods, community norms, and cohesion—that affect the health of Hartford residents. The key will be to move from funding the documentation of needs to addressing them in a coherent and sustainable manner.

## Conclusion

We may all agree that addressing the social determinants of health is the critical path toward "total population health" and, ultimately, health equity. But we must also acknowledge that moving from concept to real-world action will require significant start-up investment that cannot come from the providers alone. Achieving this complex transformation of care at the population level requires that we align our payment systems, our healthcare delivery systems, and our community support systems. Achieving alignment will require a formal yet dynamic framework to guide stakeholder engagement and shared decision making at the community level.


## Acknowledgments

The work ahead requires leaders to gather the collective minds of the thought leaders around us and together create the foundation to advance the delivery of healthcare. I would like to acknowledge the Saint Francis *Care* thought leaders who have contributed their expertise to this commentary: Gregory Makoul, PhD; Danyal Ibrahim, MD; Surendra Khera, MD; Adam Silverman, MD; Jess Kupec; and James Schepker.


## References


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# EXHIBIT 14b

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES
HEALTH PROGRESS

# Today's Transformational Mission: Opportunity Abounds to Bring More People Better Care

September-October 2015

By: Richard J. Gilfillan, MD

Times of great change and uncertainty breed opportunity. Entrepreneurs create new ways to meet customer needs. Leaders of established organizations explore new ways of operating. One common solution to the challenge created by change is to partner with other organizations with capabilities that fit new marketplace demands.

American health care illustrates this phenomenon well today. Alternative care delivery and reimbursement models challenge us to discover new ways to deliver better outcomes. Exchange-based insurance products demand value networks at a time when we are just learning how to best measure quality and value. As a result, we are changing our business and clinical models without really knowing what care systems work best or how the outcomes will be evaluated. Amid all this change and uncertainty, it is no surprise that we have unprecedented levels of entrepreneurial startups, mergers, acquisitions and consolidations.

As with many other Catholic health systems, Trinity Health, based in Livonia, Michigan, believes that today's challenges are merely the entrance fee for taking on great opportunities to advance our mission. In fact, we believe there has never been a better time for Catholic health care to have a positive impact on our communities and the people we serve. These new models offer the opportunity for us to be rewarded for what our mission now calls us to do — provide excellent coordinated care to as many people as possible. This objective seems to be the natural evolution of the challenge our founders overcame as they spread across the country to provide direct acute patient care to individuals in need.

## BUILT ON A BOLD FOUNDATION

The story of Trinity Health, as with most of Catholic health care, began more than 150 years ago when congregations of women and men religious answered the call to help heal and minister to people in need across the United States. These women and men traveled far and under tough conditions to serve others, especially vulnerable and marginalized populations. In the context of their times, these remarkable individuals built facilities and developed services from almost nothing, then continually looked at what they

could do next to help more people. Their efforts have resulted today in Catholic health care providing 16 percent of all hospital care in our country.

It is inspiring to ponder what called these women and men to be so outrageously bold. Clearly, they were driven by their commitment to service, to being a healing presence in the communities they served. In pursuit of their mission, they were willing to take risks, some of which probably seemed extreme. At times, they were torn between going slower and trying to do too much too soon. They chose to err on the side of moving forward assertively. They understood they could not linger until the right choices became obvious and that inaction carried risks of its own. In the face of great uncertainty, they moved boldly forward.

Today we are poised upon this foundation to build the health care system that our country needs for tomorrow. There are great uncertainties and risks associated with transforming our system, but we do not come from a legacy of excessive caution. That is why, at Trinity Health, we have framed a strategic transformation effort to build a people-centered health system — designed and operated to put the needs of people we serve at the center of all we do. We believe this strategy injects the bold intent of our founding congregations' missions into our work today.

Delivering people-centered care will require us to have many new operational capabilities. We will build some of these ourselves; others we will gain through partnerships with organizations that have more experience and skill. Across Catholic health care, we have seen many creative approaches to partnerships. Systems are collaborating with for-profits and not-for-profits, creating networks of nontraditional alliances and forming subsidiaries in areas such as research, insurance, telemedicine, home health, information technology and physician practice management.

MISSION IN ACTION

Our strategic plan, "People-Centered 2020," puts our mission into action and includes several key components. The first is to transform the way we deliver and are paid for providing care. To accomplish this, we have moved aggressively to develop new internal capabilities like our accountable care organization expertise. Although the Centers for Medicare and Medicaid Services' post-Affordable Care Act reimbursement playbook is still evolving, we have established Medicare Shared Savings ACOs in 18 of our 21 Regional Health Ministries. We have built out a set of new population health management activities that are essential for operating a successful ACO clinical and business model.

We also are participating broadly in the CMS Bundled Payments for Care Improvement program, with 53 facilities (38 hospitals, 12 continuing care facilities and three home health agencies) contracted for 40 different episodes of care as of Oct. 1, 2015. We are partnering with several different organizations that bring specific expertise in managing episode-based clinical models.

We also have partnered with other parties to build expanded provider networks. In Michigan, we partnered with Ascension to co-found Together Health Network, a physician-led, statewide, clinically integrated network of 25 hospitals and hundreds of ambulatory centers and physician offices. The network enables its member hospitals, physicians and other providers to jointly participate in the launch of new health plan products that give consumers greater choice and access to value-based health care services. Across our entire system, we have partnered with payers to establish 12 new value network products to date; with 18 more in development.

To develop the ability to manage full-risk capitation with payers, we established a joint venture, Trinity Health Partners, with Heritage Provider Network. Heritage has a 30-year history of successful contracting with insurers for full-risk capitation. This joint venture will develop care networks similar to ACOs, including primary care physicians, hospitals, clinics and other providers who join together to manage care for populations of patients. These networks will contract with insurers to assume full financial risk for managing these populations, which means they will be paid a set amount per patient and will be fully

responsible for covering any costs that exceed the payment. The Heritage relationship provides us with access to operational capabilities that have demonstrated success under capitation arrangements.

During the past year, we have formed a clinical care partnership with Walgreens to explore new possibilities provided by retail vendors. They will offer their stores in our facilities in select markets — enabling outpatient pharmacy services and expanded prescription and disease management programs to support people's health, while at the same time increasing consumers' access and lowering overall health care costs. We also are partnering with the Sharecare company to provide a digital consumer engagement platform. It provides a state-of-the-art, online environment that supports millions of people in their efforts to live healthier lives, and it helps them connect with physicians and remain personally engaged in their ongoing care.

Our plan also calls us to attempt to impact the transformation of our system nationally. That is why we joined with a group of Catholic health systems including Ascension, OSF Healthcare, Providence Health & Services, SLC Health and SSM Health, as well as other industry participants, to form the Health Care Transformation Task Force. Its goal is to bring together like-minded providers, payers, employers and patient advocacy groups to facilitate the path to transformation. Members include six of the nation's largest 15 health systems and four of the largest 25 health insurers. Together, we have committed to put 75 percent of our business into value-based arrangements that focus on better health, better care and lower costs by 2020. The task force has produced a number of policy recommendations, including several to CMS and the federal Department of Health and Human Services that we believe are helping to drive payment changes that support our transformation goals.

Our "People-Centered 2020" plan envisions significant growth in current communities, as well as expansion into new communities. Just as our founding congregations constantly reached out to new populations, we recognize that with the change and uncertainty in health care, there are significant opportunities to support existing Catholic health care ministries in communities that we do not serve today.

Our objective is not simply to be larger. It is to be an effective partner capable of bringing real value to regional Catholic health systems pursuing a similar mission. We believe we can provide significant economies of scale to some ministries, along with more sophisticated operational capabilities that allow them to continue their regional missions. These partnerships allow us to bring new ideas and competencies to smaller regional ministries faster. These are two-way partnerships. Within them, we share our knowledge and also learn from our new local ministries, identifying best practices that we can spread to other ministries in our system.

Our growth team, under Scott Nordlund, has developed a set of screening criteria to help us identify appropriate partners. These criteria look at a full range of operational dimensions, but start with an evaluation of mission alignment.

On July 1, 2015, St. Joseph's Health in Syracuse, New York, became a part of Trinity Health. (See story, page 18). This partnership extends our healing ministry to central New York, complementing our presence in Buffalo and Albany. We also signed a definitive agreement with Saint Francis Care, a health delivery system anchored in Hartford, Connecticut, to join Trinity Health. This merger expands our ability to work with community physicians and clinicians, providing better care coordination for people across New England, and extends Catholic care in the region.

RESPONSIBLE RISKS

Our strategy, of course, is not without risks. Our board and our leadership team often reflect on our legacy. They recognize that those who founded our organizations answered the call to help heal and minister to communities across the United States and faced far greater risks. They led the way, leaving a legacy of bold leadership for us to follow.

All health care organizations and leaders, not just those in Catholic health care, are living in this challenging environment of constant change and uncertainty. We all are struggling with the same issues of how far to move and how fast. Based on how we are working together in the task force, and what I hear as I talk with other health system leaders, I believe we are poised at a point where a transformation to a people-centered health system is possible. As leaders, we know that today's challenges offer us the once-in-a-lifetime opportunity to make our health care system right for our children and our country.

My hope is that, individually and collectively, we will seize this opportunity. We will need to be creative internally and externally, and that includes rethinking our approaches to operations and partnerships and always assessing our choices for alignment with our mission. As mission-driven organizations grounded in service to our communities, Catholic health systems are perfectly positioned to lead the way and build this new system of health care.

RICHARD J. GILFILLAN is president and CEO of Trinity Health, Livonia, Michigan.

# EXHIBIT 15

**Naugatuck Valley Women's Health Specialists**
www.nvwhs.com

David Polke, MD
S. Mark Albini, MD
Irina Magidina, MD
Melanie B. Mund, MD
Deborah Garber, CNM

November 11, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area . Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

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I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

S. Mark Albini, M.D.

State of Connecticut

**HOUSE OF REPRESENTATIVES**
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

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October 22, 2015

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P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based


www.RepArtONeill.com

accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services and support physician alignment and initiatives.

Sincerely,

Arthur O'Neill
State Representative
69th District
Bridgewater, Roxbury, Southbury and Washington

Rohit Beri, MD, FCCP

November 11, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

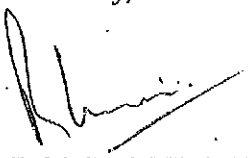
As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve

is approved, it will allow Saint Mary's physician's access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,



Rohit Beri, MD, FCCP
Director, Medical ICU
St. Mary's Hospital
Waterbury, CT

*Franklin Pulmonary Group* *133 Scovill Street, Suite 104* *Waterbury, CT 06706*
*Phone (203) 709-6244* *Fax (203) 709-3704*

# State of Connecticut

## HOUSE OF REPRESENTATIVES
STATE CAPITOL

**REPRESENTATIVE ANTHONY J. D'AMELIO**
SEVENTY-FIRST ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

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Anthony.DAmelio@housegop.ct.gov

**HOUSE REPUBLICAN WHIP**

**MEMBER**
COMMERCE COMMITTEE
GENERAL LAW COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

October 26, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone:

I am writing in strong support of Saint Mary's application to sell its assets to Trinity Health Corporation, a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's is a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Tony D'Amelio
State Representative, 71st District

**Family Footcare, PC**
James M. DeJesus, DPM, FACFAS
David W. Mader, DPM, FACFAS
Betty M. Carreira, DPM

November 11, 2015

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

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Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO

**1183 New Haven Rd · Naugatuck, CT 06770 · Phone (203) 723-7884 · Fax (203) 723-2946**
**52 Federal Rd · Unit 1A · Danbury, CT 06810 · Phone (203) 792-3668 · Fax (203) 796-7478**
**77 Main St North · Suite 104 · Southbury, CT 06488 · Phone (203) 405-6501 · Fax (203) 405-6504**

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

James M. DeJesus, DPM, FACFAS

**1183 New Haven Rd · Naugatuck, CT 06770 · Phone (203) 723-7884 · Fax (203) 723-2946**
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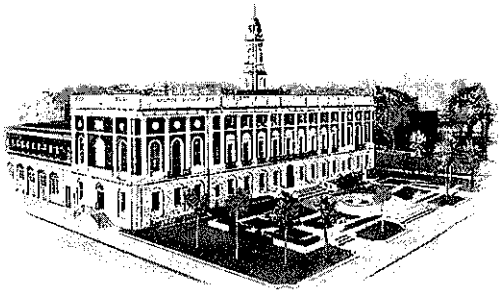

DEPARTMENT OF PUBLIC HEALTH

# THE CITY OF WATERBURY

CONNECTICUT

October 26, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

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We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

William Quinn
Director of Public Health
Waterbury Health Department

One Jefferson Square • Waterbury, Connecticut 06706-1102 • (203) 574-6780 • FAX (203) 597-3481

NOSS

Neurosurgery, Orthopaedics
& Spine Specialists, PC

Neurosurgery

Michael E. Karnasiewicz, MD, ABNS
*Neurosurgery & Spine Care*

Jarob N. Mushaweh, MD, ABNS
*Neurosurgery & Spine Care*

Alan S. Waitze, MD, ABNS
*Neurosurgery & Spine Care*

John G. Strugar, MD
*Neurosurgery & Spine Care*

David L. Forshaw, MD
*Neurosurgery & Spine Care*

Judith L. Gorelick, MD, FAANS, FACS
*Neurosurgery & Spine Care*

Orthopaedics

Glenn G. Taylor, MD, ABOS
*Orthopaedic Surgery & Spine Care*

William F. Flynn, Jr., MD, ABOS
*Joint Reconstruction & Sports Medicine*

Frederick J. Watson, MD, ABOS
*Orthopaedic Surgery & Sports Medicine*

Pain Management
and Rehabilitation

Tamer B. Ghaly, MD
*Interventional Pain Management*

Thomas Mathew, MD
*Interventional Physiatry*

Alisa H. Darling, MD, ABPMR
*Physical Medicine & Rehabilitation*
*Electrodiagnostic Medicine*

Mark A. Mashia, DC, MS
*Chiropractic Physician, Acupuncture*

November 12, 2015

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

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Dear Ms. Martone,

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Main Office 500 Chase Parkway, Waterbury, CT 06708
Satellite Offices Shelton, CT - Southbury, CT - Torrington, CT
Phone (203) 755-NOSS (6677) (800) 463-8764
Fax Neurosurgery: (203) 573-9182 Orthopaedics: (203) 755-7166 Spine/physiatry: (203) 573-1272
Web www.nossmd.com

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

David L. Forshaw, M.D.

# Saint Bridget Church

November 06, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, Connecticut 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

As a concerned citizen, and a local Pastor, I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful in this ever-changing and challenging environment. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

175 Main Street, Cheshire, Connecticut 06410
Phone 203-272-3531 • Fax 203-271-3356

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's Health System has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Rev. Jeffrey V. Romans

The Reverend Jeffrey V. Romans
Pastor

FOR YOUTH DEVELOPMENT
**FOR HEALTHY LIVING**
FOR SOCIAL RESPONSIBILITY

November 5, 2015

Ms. Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
P.O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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As a non-profit social service organization in Waterbury, it is very important to me who is in charge of operating the Hospital and its outpatient services. Saint Mary's has an outstanding reputation for its quality of patient care. I believe that Trinity, which now includes Saint Francis Care as one of its partners, will add to that quality, by leaving most of the Saint Mary's services as they are today, but with the financial resources to make existing services even better. Access to capital, as well as funding during the first five years after the acquisition, will make Saint Mary's stronger and more able to meet the needs of the community.

I strongly recommend you approve the application submitted by Saint Mary's and Trinity Health Corporation.

Respectfully submitted,

James M. O'Rourke
Chief Executive Officer

**136 West Main Street, Waterbury, CT** 06702 p: 203-754-YMCA f: 203-754-9095 www.waterburyymca.org

# State of Connecticut

## SENATE

**SENATOR JOE MARKLEY**
SIXTEENTH DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
CAPITOL: (860) 240-0381
TOLL FREE: (800) 842-1421
E-MAIL: Joe.Markley@cga.ct.gov
WEBSITE: www.SenatorMarkley.com

**ASSISTANT MINORITY LEADER/SCREENING CHAIRMAN**

**RANKING MEMBER**
HUMAN SERVICES COMMITTEE
PUBLIC HEALTH COMMITTEE

**MEMBER**
APPROPRIATIONS COMMITTEE
PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

October 26, 2015

Kimberly R. Martone
CT Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

It is a pleasure to write in support of the application of Saint Mary's Health System to sell its assets to Trinity Health Corporation, a non-profit, Catholic healthcare system active in twenty-one states.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals need substantial resources to offer quality care to their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support necessary for stability and success.

I have great confidence in the decision-makers at Saint Mary's, and I know they have the respect of the community at large. I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Joe Markley
State Senator
Sixteenth District

CHESHIRE, PROSPECT, SOUTHINGTON, WATERBURY, WOLCOTT

Franklin Medical
GROUP, PC

November 12, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

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Kimberly R. Martone
Office of health Care Access
November 12, 2015

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I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Paul Kelly, MD
Chief of Cardiology

# State of Connecticut

## HOUSE OF REPRESENTATIVES
STATE CAPITOL

**REPRESENTATIVE LEZLYE ZUPKUS**
EIGHTY-NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

TOLL FREE: 1-800-842-1423
CAPITOL: (860) 240-8700
FAX: (860) 240-0207
Lezlye.Zupkus@housegop.ct.gov

**RANKING MEMBER**
PUBLIC SAFETY AND SECURITY COMMITTEE

**MEMBER**
GENERAL LAW COMMITTEE
HUMAN SERVICES COMMITTEE

October 29, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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Kimberly R. Martone
CT DPH Office of Health Care Access
10/29/15

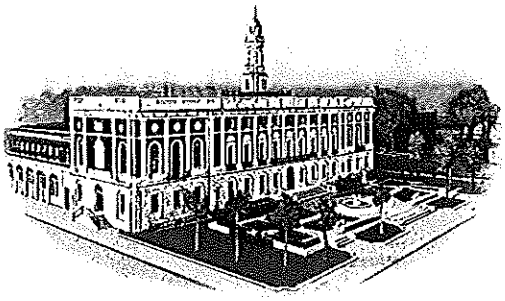
We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

State Representative Lezlye Zupkus

NEIL M. O'LEARY
MAYOR



JOSEPH A. GEARY
CHIEF OF STAFF

OFFICE OF THE MAYOR

# THE CITY OF WATERBURY

CONNECTICUT

October 21, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to become part of the Trinity Health Corporation. This acquisition by Trinity will allow Saint Mary's to become affiliated with Saint Francis Care in Hartford as well as Trinity. Saint Francis and Saint Mary's will become part of a Regional Health Ministry in Connecticut (NE-RHM) that will include hospitals and health systems in western Massachusetts as well. By joining Trinity's network of over 86 hospitals in the country, Saint Mary's will have access to a vast range of services and initiatives such as clinical quality initiatives, information technology and supply chain initiatives as well as the financial support that comes as part of a larger network. Financial support is critical in order to meet higher health expectations that have developed in the past few years. Saint Mary's is an outstanding community hospital serving the people of this City, and it needs support from a larger network to continue to provide the same excellent care to a growing number of people.

The demands of the new healthcare laws and the expense of operating a large hospital in downtown Waterbury and a system with 18 service towns will put enormous pressure on Saint Mary's in the future. Trinity is capable of helping Saint Mary's continue to provide exceptional care to the people of Waterbury and the greater Waterbury community. Saint Mary's carefully considered other alternatives,

but found that Trinity had the philosophy and commitment to the same core values that Saint Mary's has maintained for over one hundred years. Top among these values are fulfilling the community-based mission, delivering quality care and adhering to the Ethical and Religious Directives that are part of Saint Mary's Catholic identity.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc. and the Regional Health Ministry formed in CT by Trinity Health Corporation and Saint Francis Care, Inc.

Sincerely,

Neil M. O'Leary, Mayor

SS. Peter & Paul Church

67 Southmayd Road

Waterbury, CT 06705

November 11, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

Kimberly R. Martone
CT DPH Office of Health Care Access
[Date]

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Msgr James D. Coleman
[Name]

Saint Mary's
HOSPITAL

November 5, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

Saint Mary's
HOSPITAL

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Philip R Corvo MD MA FACS

Philip R Corvo MD MA FACS
Chairman, Department of Surgery
Director, Surgical Critical Care
Stanley J Dudrick Department of Surgery
Institutional Official
Saint Mary's Hospital, Waterbury, Connecticut
Governor-At-Large, American College of Surgeons
Past President, Connecticut Chapter of the American College of Surgeons
Past Health Commissioner, City of Stamford

# State of Connecticut

## HOUSE OF REPRESENTATIVES
STATE CAPITOL

**REPRESENTATIVE ANTHONY J. D'AMELIO**
SEVENTY-FIRST ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

TOLL FREE: (800) 842-1423
FAX: (860) 240-0207
Anthony.DAmelio@housegop.ct.gov

**HOUSE REPUBLICAN WHIP**

**MEMBER**
COMMERCE COMMITTEE
GENERAL LAW COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

October 26, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone:

I am writing in strong support of Saint Mary's application to sell its assets to Trinity Health Corporation, a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's is a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Tony D'Amelio
State Representative, 71st District

State of Connecticut

**HOUSE OF REPRESENTATIVES**
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

**REPRESENTATIVE ARTHUR J. O'NEILL**
SIXTY-NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

HOME: (203) 264-3112
TOLL FREE: (800) 842-1423
FAX: (860) 240-0207
Arthur.ONeill@housegop.ct.gov

**DEPUTY REPUBLICAN LEADER**

**CHAIRMAN**
LAW REVISION COMMISSION

**MEMBER**
APPROPRIATIONS COMMITTEE
JUDICIARY COMMITTEE
REGULATION REVIEW COMMITTEE
JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT

October 22, 2015

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based

accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services and support physician alignment and initiatives.

Sincerely,

Arthur O'Neill
State Representative
69th District
Bridgewater, Roxbury, Southbury and Washington

# State of Connecticut

**HOUSE OF REPRESENTATIVES**
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

**REPRESENTATIVE CRAIG A. MINER**
SIXTY-SIXTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

HOME: (860) 567-4757
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Craig.Miner@housegop.ct.gov

**DEPUTY REPUBLICAN LEADER**

**MEMBER**
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE
LABOR AND PUBLIC EMPLOYEES COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Healthcare Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I write today in strong support of Saint Mary's Hospital application to sell its assets to Trinity Health Corporation.

As a legislator, I know that many of my constituents have greatly benefitted from the dedicated service that the medical professionals at Saint Mary's Hospital have given them over the years. The approval of this acquisition will allow Saint Mary's to continue serving so many within our community with the backing of Trinity Health Corporation.

The health care industry has changed greatly in recent years and smaller, independent hospitals will struggle in the future to deliver the same caliber of care that they have in the past. By merging with Saint Francis Care, and then with both eventually being acquired by Trinity Health Corporation, Saint Mary's can look to the future with a strong partner.

Thank you for your consideration of this request. If I can be of any further assistance in this matter, please do not hesitate to contact my office.

Sincerely,

Craig Miner
*State Representative*
*66th District*

State of Connecticut

**HOUSE OF REPRESENTATIVES**
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

**REPRESENTATIVE DAVID K. LABRIOLA**
ONE HUNDRED THIRTY-FIRST ASSEMBLY DISTRICT

185 RIGGS STREET
OXFORD, CONNECTICUT 06478
TOLL FREE:(800) 842-1423
FAX: 860-240-0207
David.Labriola@housegop.ct.gov

**HOUSE REPUBLICAN WHIP**

**MEMBER**
TRANSPORTATION COMMITTEE
GOVERNMENT ADMINISTRATION AND ELECTIONS COMMITTEE
JUDICIARY COMMITTEE

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

Kimberly R. Martone
CT DPH Office of Health Care Access
November 5, 2015

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Dave

David Labriola
State Representative
131st District
Naugatuck and Oxford

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

Representative David Zoni
81st Assembly District
Southington

Legislative Office Building
Hartford, Connecticut 06106
860-240-8585 or 800-842-8267
David.Zoni@cga.ct.gov

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

State Representative David Zoni
81st District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ERIC C. BERTHEL
SIXTY-EIGHTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

CAPITOL: (860) 240-8700
TOLL FREE: (800) 842-1423
Eric.Berthel@housegop.ct.gov

MEMBER
EDUCATION COMMITTEE
FINANCE, REVENUE AND BONDING COMMITTEE
PUBLIC HEALTH COMMITTEE

November 9, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Eric C. Berthel
State Representative – 68th District

# State of Connecticut

## HOUSE OF REPRESENTATIVES
STATE CAPITOL

**REPRESENTATIVE LEZLYE ZUPKUS**
EIGHTY-NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

TOLL FREE: 1-800-842-1423
CAPITOL: (860) 240-8700
FAX: (860) 240-0207
Lezlye.Zupkus@housegop.ct.gov

**RANKING MEMBER**
PUBLIC SAFETY AND SECURITY COMMITTEE

**MEMBER**
GENERAL LAW COMMITTEE
HUMAN SERVICES COMMITTEE

October 29, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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Kimberly R. Martone
CT DPH Office of Health Care Access
10/29/15

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

State Representative Lezlye Zupkus

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE SELIM G. NOUJAIM
SEVENTY FOURTH ASSEMBLY DISTRICT

104 DINATALI DRIVE
WATERBURY, CT 06705

TOLL FREE: (800) 842-1423
HOME: (203) 591-9190
Selim.Noujaim@housegop.ct.gov

HOUSE REPUBLICAN WHIP

CHAIRMAN
REGULATIONS REVIEW COMMITTEE

MEMBER
COMMERCE COMMITTEE
EXECUTIVE AND LEGISLATIVE NOMINATIONS
INTERNSHIP COMMITTEE

Date: October 23, 2015

Ms. Kimberly R. Martone, Director of Operations

CT Department of Public Health

Office of Health Care Access

410 Capitol Avenue PO Box 340308

Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System

and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully,

Selim G. Noujaim

Selim G. Noujaim

Saint Mary's
HOSPITAL

## Department of Dentistry

November 11, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

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As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area.

Kimberly R. Martone
Office of Health Care Access
November 11, 2015

Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

*Richard Putnam, D.M.D., F.A.G.D.*
*Chief, Department of Dentistry*
*Director, GPR Program*
*Saint Mary's Hospital*
*133 Scovill Street*
*Waterbury, CT 06706*
*203-709-7055 - phone*
*203-709-7750 -fax*
*richard.putnam@stmh.org*

Waterbury ORTHOPAEDIC ASSOCIATES, PC

ERIC J. OLSON, M.D.
DENNIS M. RODIN, M.D.
MICHELLE MARIANI, M.D.

ALAN HOULE, PA-C
PAM NOLE, ADMINISTRATOR

November 12, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and

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Tel: (203) 755-0163 Fax: (203) 753-3415
www.waterburyortho.com

provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

Dennis Rodin, MD

1211 West Main Street
Waterbury, CT 06708-3178
Tel: (203) 755-0163 Fax: (203) 753-3415
www.waterburyortho.com

Main St. Waterbury

Culture Education Business

November 9, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

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We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

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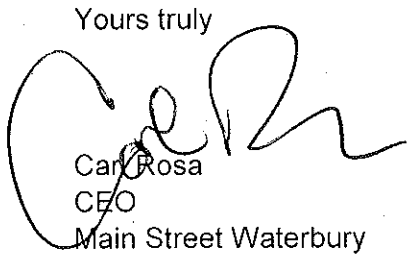
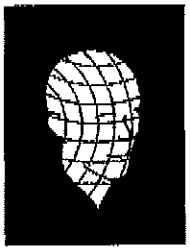
203.757.0701 • 203.756.3507 Fax • www.mainstreetwaterbury.com

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Yours truly



Carl Rosa
CEO
Main Street Waterbury



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Fax (203) 264-2920

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Apple Valley Mall
Southington, CT 06489
Tel (860) 276-0422
Fax (860) 276-0828

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November 11, 2015

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

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

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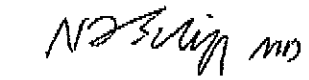
I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely yours,



Neil F. Schiff, M.D.
President, CT ENT
Fellow AAO/HNS

# State of Connecticut

## SENATE

**SENATOR JOE MARKLEY**
SIXTEENTH DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
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TOLL FREE: (800) 842-1421
E-MAIL: Joe.Markley@cga.ct.gov
WEBSITE: www.SenatorMarkley.com

**ASSISTANT MINORITY LEADER/SCREENING CHAIRMAN**

**RANKING MEMBER**
HUMAN SERVICES COMMITTEE
PUBLIC HEALTH COMMITTEE

**MEMBER**
APPROPRIATIONS COMMITTEE
PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

October 26, 2015

Kimberly R. Martone
CT Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

It is a pleasure to write in support of the application of Saint Mary's Health System to sell its assets to Trinity Health Corporation, a non-profit, Catholic healthcare system active in twenty-one states.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals need substantial resources to offer quality care to their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support necessary for stability and success.

I have great confidence in the decision-makers at Saint Mary's, and I know they have the respect of the community at large. I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Joe Markley
State Senator
Sixteenth District

CHESHIRE, PROSPECT, SOUTHINGTON, WATERBURY, WOLCOTT

# State of Connecticut

## SENATE

**SENATOR ROBERT J. KANE**
THIRTY-SECOND DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
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E-MAIL: Rob.Kane@cga.ct.gov
WEBSITE: www.SenatorKane.com

**DEPUTY MINORITY LEADER PRO TEMPORE & CAUCUS CHAIRMAN FOR POLICY**

**RANKING MEMBER**
APPROPRIATIONS COMMITTEE
EXECUTIVE & LEGISLATIVE NOMINATIONS COMMITTEE

**MEMBER**
PUBLIC HEALTH COMMITTEE

10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Senator Rob Kane – 32nd District

Saint Mary's
HOSPITAL

11/12/15

Michael Simms III, MD, ABIM (ID)
Infectious Diseases
56 Franklins St.
Waterbury, CT 06706
203-709-6402

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

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Office of health Care Access

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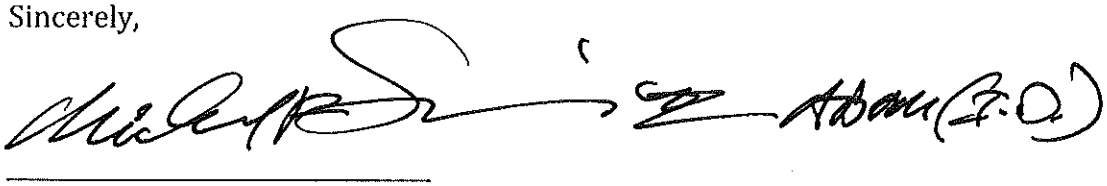

Waterbury Regional Chamber
*driving business to business*

November 5, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

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Tel: 203.757.0701 • Fax: 203.756.3337 • www.waterburychamber.com

Waterbury Regional Chamber
*driving business to business*

Kimberly R. Martone
CT DPH Office of Health Care Access
November 5, 2015

We have known for a long time that Saint Mary's was going to need an extraordinary partner to infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury. While Saint Mary's has a strong hospital now, the demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options for a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Lynn G. Ward

Lynn G. Ward
President & CEO
Waterbury Regional Chamber
83 Bank St., Fourth Floor
Waterbury, CT 06721
203-757-0701, Ext. 310
lward@waterburychamber.com

**ABDULMASIH ZARIF, M.D., LLC**
**BOARD CERTIFIED**
**GENERAL, LAPAROSCOPIC AND CANCER SURGERY**

November, 06, 2015

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

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Sincerely,

**1389 West Main Street • Tower 2 - Room 321 • Waterbury, CT 06708 • (203) 757-1113 • Fax (203) 575-9018**

# EXHIBIT 16

**EXHIBIT**
**List of Residencies**

The following is a list of residencies offered at Saint Francis through the University of Connecticut School of Medicine:

* Anesthesiology
* Emergency Medicine
* Family Medicine
* Pediatrics
* Internal Medicine (General)
* Internal Medicine (Cardiology)
* Internal Medicine (Endocrinology)
* Internal Medicine (Gastroenterology)
* Internal Medicine (Hematology/Oncology)
* Internal Medicine (Infectious Disease)
* Internal Medicine (Pulmonary/ Critical Care)
* Maternal Fetal Medicine
* Nuclear Medicine
* Orthopedic Surgery
* Otolaryngology
* Psychiatry
* Radiology
* Surgery
* Urology
* Geriatric Medicine
* Nephrology
* Primary Care Medicine

The following are the Saint Francis Residency and Fellowship programs:

* General Dentistry Residency
* Obstetrics and Gynecology Residency
* Podiatric Medicine and Surgery Residency
* Colon/Rectal Surgery Fellowship

# EXHIBIT 17

Exhibit 17

Financial Worksheets

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

Financial Worksheets including actual and projected results have been prepared for both consolidated Saint Mary's Health System, Inc. ("SMHS") and Saint Mary's Hospital (only). FY 2015 actual results are preliminary unaudited results.

General Assumptions:

- For all years, the Hospital Tax has been reclassified as an "Other Deductions" line A.4 to be consistent with Trinity Health - New England for presentation purposes.
- FY 2015 actual results include a $2.9 million receivable from the State of Connecticut for the 1st quarter supplemental payment associated with the Hospital Provider Tax for the State's FY 2016. If the State further reduces funding, actual results may differ. This amount is included in "Other Deductions", Line A.4.
- The FY 2016 revised budget includes the assumption that the State will resume the supplemental payments in the 4th quarter of FY 2016 (or 1st quarter of State FY 2017) of $2.9 million.
- As a result of the decrease in State supplemental payments, the FY 2016 budget was revised and includes the following:
    - A net increase of 117 full-time equivalents was reduced to 74 as a result of delayed hiring for open positions. In addition, the wage increase for FY 2016 was reduced to 2%,
    - Related employee benefits were also decreased approximately 3%, and
    - Other cost reduction initiatives approximating $2.3 million.
- FY 2017-2019 assumes the State Provider Tax will remain at the same level as included in the FY 2016 revised budget.

The following summarizes key assumptions used in projecting the FY 2017 - 2019 operating results:

- Inpatient volume is projected to decrease .5% each year, respectively, from FY 2017 through FY 2019 as utilization of inpatient services shifts as a result of population health management.
- Outpatient visits is projected to increase 2% each year, respectively, from FY 2017 through FY 2019 as preventive care increases as a result of population health management.
- An increase in Medicare reimbursement is included in FYs 2017-2019 as a result of a change in the Medicare wage index.
- Bad debts as a percentage of gross revenues are expected to remain flat.
- Projected salary and benefits expense includes increases of 2.5% for FY 2017 through FY 2019. While overall FTE's remain flat, the increase represents employee merit/inflation increases.

- Supplies and other expenses include inflation increases between 2%-5% for FY2017 through FY 2019.
- The existing CHEFA debt was refinanced in 2015, resulting in a reduction in Interest Expense in FY 2016-2019, Operating Expenses - Line 7.

Based on Trinity Health's historical success with the integration of hospitals and health systems into the Trinity Health system, it is expected that operational savings of approximately 1% of current annual operating expenses or $3.1 million will be realized. The incremental projected amounts are included in the financial worksheets beginning in FY 2017, realizing 50%, as we anticipate a closing on or around July 1, 2016. In FY 2018, we anticipate realizing the full 1%. Some areas where we expect to recognize these opportunities include purchased services, supply chain, insurance and risk management, treasury, tax and compliance. These reductions have been included in the financial worksheets in Lines 4 Supplies and Drugs and Line 10 Other Operating Expenses.

There are no planned changes to the clinical services offered by SMHS as a result of this transaction; however, as part of its population health and other health reform initiatives, the parties may, in the future, choose to make changes in the services offered by Trinity Health - New England or its subsidiaries that are intended to best meet the communities health care needs.

In addition to the expected operational savings noted above, the known significant financial benefits to SMHS are as follows:

- As previously noted on page 15 of the CON application, a commitment by Trinity Health to ensure investment of $100 million dollars (potentially up to $120 million) in capital that will allow SMHS to:
    - Address equipment replacement and routine facility upgrades that have been delayed due to the recent reductions in state and federal healthcare funding; and
    - Make additional strategic investments in healthcare initiatives as opportunities arise over the next 5 years, including those necessary to move towards risk-based contracting.

  Refer to page 72-73 of the CON application for approximate allocation of capital spending and needs.

- Ability to access capital financing at favorable rates through Trinity Health - New England via Trinity Health's intercompany loan program.
- Support to enable SMHS to adequately fund its pension obligations.
- Access to Trinity Health - New England and Trinity Health system services to promote efficient and effective care delivery.

Note: The impact of the financial commitment by Trinity Health of $100 million (potentially up to $120 million) has not been included in the projections because the allocation of these funds has not yet occurred.

If any proposed investment requires additional regulatory approval, this approval will be obtained prior to the investment being made.

**NON-PROFIT**

**Saint Mary's Health System, Inc.**

**Financial Worksheet (A)**

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

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **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 | $832,217 | $873,828 | | $873,828 | $917,519 | | $917,519 | $963,395 | | $963,395 | $1,011,565 | | $1,011,565 |
| 2 | Less: Allowances | $535,300 | $558,162 | | $558,162 | $592,210 | | $592,210 | $628,335 | | $628,335 | $666,663 | | $666,663 |
| 3 | Less: Charity Care | $1,854 | $2,500 | | $2,500 | $2,625 | | $2,625 | $2,756 | | $2,756 | $2,894 | | $2,894 |
| 4 | Less: Other Deductions | $4,232 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 |
| | **Net Patient Service Revenue** | **$290,831** | **$303,420** | **$0** | **$303,420** | **$312,938** | **$0** | **$312,938** | **$322,558** | **$0** | **$322,558** | **$332,262** | **$0** | **$332,262** |
| 5 | Medicare | $115,320 | $124,657 | | $124,657 | $127,442 | | $127,442 | $130,173 | | $130,173 | $132,837 | | $132,837 |
| 6 | Medicaid | $55,779 | $51,255 | | $51,255 | $51,391 | | $51,391 | $51,470 | | $51,470 | $51,492 | | $51,492 |
| 7 | CHAMPUS & TriCare | $257 | $264 | | $264 | $268 | | $268 | $271 | | $271 | $274 | | $274 |
| 8 | Other | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | **Total Government** | **$171,356** | **$176,176** | **$0** | **$176,176** | **$179,101** | **$0** | **$179,101** | **$181,914** | **$0** | **$181,914** | **$184,603** | **$0** | **$184,603** |
| 9 | Commercial Insurers | $108,375 | $115,495 | | $115,495 | $121,554 | | $121,554 | $127,811 | | $127,811 | $134,262 | | $134,262 |
| 10 | Uninsured | $709 | $727 | | $727 | $736 | | $736 | $744 | | $744 | $751 | | $751 |
| 11 | Self Pay | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 12 | Workers Compensation | $9,139 | $9,739 | | $9,739 | $10,250 | | $10,250 | $10,778 | | $10,778 | $11,322 | | $11,322 |
| 13 | Other | $1,252 | $1,283 | | $1,283 | $1,297 | | $1,297 | $1,311 | | $1,311 | $1,324 | | $1,324 |
| | **Total Non-Government** | **$119,475** | **$127,244** | **$0** | **$127,244** | **$133,837** | **$0** | **$133,837** | **$140,644** | **$0** | **$140,644** | **$147,659** | **$0** | **$147,659** |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | **$290,831** | **$303,420** | **$0** | **$303,420** | **$312,938** | **$0** | **$312,938** | **$322,558** | **$0** | **$322,558** | **$332,262** | **$0** | **$332,262** |
| 14 | Less: Provision for Bad Debts | $9,675 | $9,990 | | **$9,990** | $10,490 | | **$10,490** | $11,014 | | **$11,014** | $11,565 | | **$11,565** |
| | **Net Patient Service Revenue less provision for bad debts** | **$281,156** | **$293,430** | **$0** | **$293,430** | **$302,449** | **$0** | **$302,449** | **$311,544** | **$0** | **$311,544** | **$320,697** | **$0** | **$320,697** |
| 15 | Other Operating Revenue | $8,248 | $7,253 | | **$7,253** | $7,253 | | **$7,253** | $7,253 | | **$7,253** | $7,253 | | **$7,253** |
| 17 | Net Assets Released from Restrictions | $733 | $733 | | **$733** | $733 | | **$733** | $733 | | **$733** | $733 | | **$733** |
| | **TOTAL OPERATING REVENUE** | **$290,137** | **$301,416** | **$0** | **$301,416** | **$310,435** | **$0** | **$310,435** | **$319,530** | **$0** | **$319,530** | **$328,683** | **$0** | **$328,683** |
| **B.** | **OPERATING EXPENSES** | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $123,041 | $132,928 | | $132,928 | $136,251 | | $136,251 | $139,657 | | $139,657 | $143,149 | | $143,149 |
| 2 | Fringe Benefits | $32,244 | $30,602 | | $30,602 | $31,367 | | $31,367 | $32,151 | | $32,151 | $32,955 | | $32,955 |
| 3 | Physicians Fees | $9,915 | $11,031 | | $11,031 | $11,362 | | $11,362 | $11,703 | | $11,703 | $12,054 | | $12,054 |
| 4 | Supplies and Drugs | $47,026 | $48,991 | | $48,991 | $51,441 | ($720) | $50,720 | $54,013 | ($1,512) | $52,500 | $56,713 | ($1,588) | $55,125 |
| 5 | Depreciation and Amortization | $11,502 | $11,713 | | $11,713 | $12,064 | | $12,064 | $12,426 | | $12,426 | $12,799 | | $12,799 |
| 6 | Provision for Bad Debts-Other[b] | | | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | Interest Expense | $979 | $231 | | $231 | $219 | | $219 | $208 | | $208 | $198 | | $198 |
| 8 | Malpractice Insurance Cost | $5,572 | $5,917 | | $5,917 | $6,035 | | $6,035 | $6,156 | | $6,156 | $6,279 | | $6,279 |
| 9 | Lease Expense | | | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Other Operating Expenses | $57,631 | $55,648 | | $55,648 | $56,761 | ($817) | $55,944 | $57,896 | ($1,621) | $56,275 | $59,054 | ($1,654) | $57,401 |
| | **TOTAL OPERATING EXPENSES** | **$287,910** | **$297,061** | **$0** | **$297,061** | **$305,501** | **($1,538)** | **$303,963** | **$314,211** | **($3,133)** | **$311,078** | **$323,201** | **($3,241)** | **$319,960** |
| | **INCOME/(LOSS) FROM OPERATIONS** | **$2,227** | **$4,355** | **$0** | **$4,355** | **$4,934** | **$1,538** | **$6,472** | **$5,319** | **$3,133** | **$8,453** | **$5,482** | **$3,241** | **$8,723** |
| | **NON-OPERATING REVENUE** | **$2,190** | **$2,877** | | **$2,877** | **$2,963** | | **$2,963** | **$3,052** | | **$3,052** | **$3,144** | | **$3,144** |
| | **EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES** | **$4,417** | **$7,232** | **$0** | **$7,232** | **$7,897** | **$1,538** | **$9,435** | **$8,371** | **$3,133** | **$11,505** | **$8,625** | **$3,241** | **$11,867** |
| | Principal Payments | **$3,000** | $3,000 | | **$3,000** | $3,000 | | **$3,000** | $3,000 | | **$3,000** | $3,000 | | **$3,000** |

**NON-PROFIT**

**Saint Mary's Health System, Inc.**

**Financial Worksheet (A)**

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

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **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.** | **PROFITABILITY SUMMARY** | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | **0.8%** | **1.4%** | **0.0%** | **1.4%** | **1.6%** | **0.0%** | **2.1%** | **1.6%** | **0.0%** | **2.6%** | **1.7%** | **0.0%** | **2.6%** |
| 2 | Hospital Non Operating Margin | **0.7%** | **0.9%** | **0.0%** | **0.9%** | **0.9%** | **0.0%** | **0.9%** | **0.9%** | **0.0%** | **0.9%** | **0.9%** | **0.0%** | **0.9%** |
| 3 | Hospital Total Margin | **1.5%** | **2.4%** | **0.0%** | **2.4%** | **2.5%** | **0.0%** | **3.0%** | **2.6%** | **0.0%** | **3.6%** | **2.6%** | **0.0%** | **3.6%** |
| | | | | | | | | | | | | | | |
| **D.** | **FTEs** | **1,680** | 1,754 | | **1,754** | 1,754 | | **1,754** | 1,754 | | **1,754** | 1,754 | | **1,754** |
| | | | | | | | | | | | | | | |
| **E.** | **VOLUME STATISTICS[c]** | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 11,847 | 11,875 | | **11,875** | 11,816 | | **11,816** | 11,757 | | **11,757** | 11,698 | | **11,698** |
| 2 | Outpatient Visits | 238,522 | 246,611 | | **246,611** | 251,543 | | **251,543** | 256,574 | | **256,574** | 261,706 | | **261,706** |
| | **TOTAL VOLUME** | **250,369** | **258,486** | **0** | **258,486** | **263,359** | **0** | **263,359** | **268,331** | **0** | **268,331** | **273,404** | **0** | **273,404** |

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

**NON-PROFIT**

**Saint Mary's Hospital (only)**

**Financial Worksheet (A)**

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

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **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 | $746,752 | $786,099 | | $786,099 | $825,404 | | $825,404 | $866,674 | | $866,674 | $910,008 | | $910,008 |
| 2 | Less: Allowances | $484,798 | $513,815 | | $513,815 | $545,158 | | $545,158 | $578,412 | | $578,412 | $613,695 | | $613,695 |
| 3 | Less: Charity Care | $1,854 | $1,947 | | $1,947 | $2,044 | | $2,044 | $2,146 | | $2,146 | $2,254 | | $2,254 |
| 4 | Less: Other Deductions | $4,232 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 |
| | **Net Patient Service Revenue** | **$255,868** | **$260,591** | **$0** | **$260,591** | **$268,456** | **$0** | **$268,456** | **$276,370** | **$0** | **$276,370** | **$284,313** | **$0** | **$284,313** |
| 5 | Medicare | $101,452 | $107,051 | | $107,051 | $110,282 | | $110,282 | $113,533 | | $113,533 | $116,796 | | $116,796 |
| 6 | Medicaid | $49,075 | $44,014 | | $44,014 | $45,342 | | $45,342 | $46,679 | | $46,679 | $48,020 | | $48,020 |
| 7 | CHAMPUS & TriCare | $205 | $208 | | $208 | $215 | | $215 | $221 | | $221 | $227 | | $227 |
| 8 | Other | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | **Total Government** | **$150,732** | **$151,273** | **$0** | **$151,273** | **$155,839** | **$0** | **$155,839** | **$160,433** | **$0** | **$160,433** | **$165,044** | **$0** | **$165,044** |
| 9 | Commercial Insurers | $95,439 | $99,181 | | $99,181 | $102,174 | | $102,174 | $105,186 | | $105,186 | $108,209 | | $108,209 |
| 10 | Uninsured | $614 | $599 | | $599 | $617 | | $617 | $636 | | $636 | $654 | | $654 |
| 11 | Self Pay | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 12 | Workers Compensation | $8,034 | $8,339 | | $8,339 | $8,591 | | $8,591 | $8,844 | | $8,844 | $9,098 | | $9,098 |
| 13 | Other | $1,049 | $1,199 | | $1,199 | $1,235 | | $1,235 | $1,271 | | $1,271 | $1,308 | | $1,308 |
| | **Total Non-Government** | **$105,136** | **$109,318** | **$0** | **$109,318** | **$112,617** | **$0** | **$112,617** | **$115,937** | **$0** | **$115,937** | **$119,269** | **$0** | **$119,269** |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | **$255,868** | **$260,591** | **$0** | **$260,591** | **$268,456** | **$0** | **$268,456** | **$276,370** | **$0** | **$276,370** | **$284,313** | **$0** | **$284,313** |
| 14 | Less: Provision for Bad Debts | $8,180 | $8,512 | | **$8,512** | $8,938 | | **$8,938** | $9,384 | | **$9,384** | $9,854 | | **$9,854** |
| | **Net Patient Service Revenue less provision for bad debts** | **$247,688** | **$252,079** | **$0** | **$252,079** | **$259,519** | **$0** | **$259,519** | **$266,985** | **$0** | **$266,985** | **$274,459** | **$0** | **$274,459** |
| 15 | Other Operating Revenue | $7,473 | $6,267 | | **$6,267** | $6,267 | | **$6,267** | $6,267 | | **$6,267** | $6,267 | | **$6,267** |
| 17 | Net Assets Released from Restrictions | $733 | $700 | | **$700** | $700 | | **$700** | $700 | | **$700** | $700 | | **$700** |
| | **TOTAL OPERATING REVENUE** | **$255,894** | **$259,046** | **$0** | **$259,046** | **$266,486** | **$0** | **$266,486** | **$273,952** | **$0** | **$273,952** | **$281,426** | **$0** | **$281,426** |
| **B.** | **OPERATING EXPENSES** | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $88,793 | $93,086 | | $93,086 | $95,413 | | $95,413 | $97,798 | | $97,798 | $100,243 | | $100,243 |
| 2 | Fringe Benefits | $27,562 | $25,721 | | $25,721 | $26,364 | | $26,364 | $27,023 | | $27,023 | $27,699 | | $27,699 |
| 3 | Physicians Fees | $10,621 | $11,268 | | $11,268 | $11,606 | | $11,606 | $11,954 | | $11,954 | $12,313 | | $12,313 |
| 4 | Supplies and Drugs | $45,059 | $44,320 | | $44,320 | $46,536 | ($652) | $45,884 | $48,863 | ($1,368) | $47,495 | $51,306 | ($1,437) | $49,869 |
| 5 | Depreciation and Amortization | $10,805 | $11,116 | | $11,116 | $11,449 | | $11,449 | $11,793 | | $11,793 | $12,147 | | $12,147 |
| 6 | Provision for Bad Debts-Other[b] | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | Interest Expense | $963 | $216 | | $216 | $205 | | $205 | $195 | | $195 | $185 | | $185 |
| 8 | Malpractice Insurance Cost | $5,350 | $5,094 | | $5,094 | $5,196 | | $5,196 | $5,300 | | $5,300 | $5,406 | | $5,406 |
| 9 | Lease Expense | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Other Operating Expenses | $49,045 | $48,175 | | $48,175 | $49,139 | ($708) | $48,431 | $50,121 | ($1,403) | $48,718 | $51,124 | ($1,431) | $49,692 |
| | **TOTAL OPERATING EXPENSES** | **$238,198** | **$238,996** | **$0** | **$238,996** | **$245,908** | **($1,359)** | **$244,549** | **$253,048** | **($2,772)** | **$250,276** | **$260,422** | **($2,868)** | **$257,554** |
| | **INCOME/(LOSS) FROM OPERATIONS** | **$17,696** | **$20,050** | **$0** | **$20,050** | **$20,577** | **$1,359** | **$21,936** | **$20,904** | **$2,772** | **$23,676** | **$21,004** | **$2,868** | **$23,872** |
| | **NON-OPERATING REVENUE** | **$3,158** | **$3,716** | | **$3,716** | **$3,827** | | **$3,827** | **$3,942** | | **$3,942** | **$4,061** | | **$4,061** |
| | **EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES** | **$20,854** | **$23,766** | **$0** | **$23,766** | **$24,405** | **$1,359** | **$25,764** | **$24,847** | **$2,772** | **$27,618** | **$25,064** | **$2,868** | **$27,932** |
| | Principal Payments | **$3,000** | $3,000 | | **$3,000** | $3,000 | | **$3,000** | $3,000 | | **$3,000** | $3,000 | | **$3,000** |

**NON-PROFIT**

**Saint Mary's Hospital (only)**

**Financial Worksheet (A)**

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

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **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.** | **PROFITABILITY SUMMARY** | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | **6.8%** | **7.6%** | **0.0%** | **7.6%** | **7.6%** | **0.0%** | **8.1%** | **7.5%** | **0.0%** | **8.5%** | **7.4%** | **0.0%** | **8.4%** |
| 2 | Hospital Non Operating Margin | **1.2%** | **1.4%** | **0.0%** | **1.4%** | **1.4%** | **0.0%** | **1.4%** | **1.4%** | **0.0%** | **1.4%** | **1.4%** | **0.0%** | **1.4%** |
| 3 | Hospital Total Margin | **8.1%** | **9.0%** | **0.0%** | **9.0%** | **9.0%** | **0.0%** | **9.5%** | **8.9%** | **0.0%** | **9.9%** | **8.8%** | **0.0%** | **9.8%** |
| | | | | | | | | | | | | | | |
| **D.** | **FTEs** | **1,384** | **1,415** | | **1,415** | 1,415 | | **1,415** | 1,415 | | **1,415** | 1,415 | | **1,415** |
| | | | | | | | | | | | | | | |
| **E.** | **VOLUME STATISTICS[c]** | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 11,847 | 11,875 | | **11,875** | 11,816 | | **11,816** | 11,757 | | **11,757** | 11,698 | | **11,698** |
| 2 | Outpatient Visits | 238,522 | 246,611 | | **246,611** | 251,543 | | **251,543** | 256,574 | | **256,574** | 261,706 | | **261,706** |
| | **TOTAL VOLUME** | **250,369** | **258,486** | **0** | **258,486** | **263,359** | **0** | **263,359** | **268,331** | **0** | **268,331** | **273,404** | **0** | **273,404** |

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

SAINT MARY'S HEALTH SYSTEM, INC
($ in thousands)

| | | Month | | Year to Date | |
|---|---|---|---|---|---|
| | | Sept 2015 | Prior Year | Sept 2015 | Prior Year |
| **A.** | **Operating Performance** | | | | |
| | Operating Margin | -0.1% | 10.0% | 0.8% | 3.2% |
| | Non-Operating Margin | -5.0% | 4.8% | 0.7% | 1.4% |
| | Total Margin | -5.0% | 14.9% | 1.5% | 4.6% |
| | Bad Debt as % of Gross Revenue | 0.7% | 1.3% | 1.2% | 1.5% |
| **B.** | **Liquidity** | | | | |
| | Current Ratio | 1.80 | 2.21 | 1.80 | 2.21 |
| | Days Cash on Hand | 19 | 34 | 19 | 34 |
| | Days in Net Accounts Receivable | 41.72 | 41.11 | 41.72 | 41.11 |
| | Average Payment Period | 58 | 60 | 58 | 60 |
| **C.** | **Leverage and Capital Structure** | | | | |
| | Long-term Debt to Equity | 0.29 | 0.41 | 0.29 | 0.41 |
| | Long-term Debt to Capitalization | 0.23 | 0.29 | 0.23 | 0.29 |
| | Unrestricted Cash to Debt | 1.02 | 1.26 | 1.02 | 1.26 |
| | Times Interest Earned Ratio | -57.7 | 35.3 | 5.50 | 9.94 |
| | Debt Service Coverage Ratio | 4.9 | 15.0 | 4.90 | 6.92 |
| | Equity Financing Ratio | 4.31 | 4.42 | 4.31 | 4.42 |
| **D.** | **Additional Statistics** | | | | |
| | Income from Operations | $ (3) | $ 2,618 | $ 2,227 | $ 9,146 |
| | Revenue Over/(Under) Expense | $ (1,137) | $ 3,879 | $ 4,417 | $ 12,830 |
| | EBITDA | $ 1,240 | $ 3,756 | $ 14,709 | $ 21,113 |
| | Patient Cash Collected | $ 21,477 | $ 20,756 | $ 272,841 | $ 258,462 |
| | Cash and Cash Equivalents | $ 14,907 | $ 26,867 | $ 14,907 | $ 26,867 |
| | Net Working Capital | $ 17,591 | $ 29,580 | $ 17,591 | $ 29,580 |
| | Unrestricted Assets | $ 30,950 | $ 32,895 | $ 30,950 | $ 32,895 |
| | Credit Ratings (S&P, FITCH and Moody's) | Ba2 | Ba2 | Ba2 | Ba2 |

| Saint Mary's Hospital (Hospital only) | Month | | Year to Date | |
|---|---|---|---|---|
| | Sept 2015 | Prior Year | Sept 2015 | Prior Year |
| **A. Operating Performance** | | | | |
| Operating Margin | 9.0% | 15.0% | 6.8% | 8.2% |
| Non-Operating Margin | -6.0% | 6.0% | 1.2% | 2.0% |
| Total Margin | 3.0% | 21.0% | 8.0% | 10.2% |
| Bad Debt as % of Gross Revenue | 0.4% | 1.1% | 1.1% | 1.5% |
| **B. Liquidity** | | | | |
| Current Ratio | 1.62 | 2.11 | 1.62 | 2.11 |
| Days Cash on Hand | 23 | 40 | 23 | 40 |
| Days in Net Accounts Receivable | 41.36 | 41.00 | 41.36 | 41.00 |
| Average Payment Period | 61 | 64 | 61 | 64 |
| **C. Leverage and Capital Structure** | | | | |
| Long-term Debt to Equity | 0.32 | 0.43 | 0.32 | 0.43 |
| Long-term Debt to Capitalization | 0.24 | 0.30 | 0.24 | 0.30 |
| Unrestricted Cash to Debt | 0.97 | 1.24 | 0.97 | 1.24 |
| Times Interest Earned Ratio | 30.5 | 44.9 | 22.65 | 18.96 |
| Debt Service Coverage Ratio | 11.3 | 18.0 | 9.82 | 10.50 |
| Equity Financing Ratio | 4.23 | 4.00 | 4.23 | 4.00 |
| **D. Additional Statistics** | | | | |
| Income from Operations | $ 1,820,855 | $ 3,421,482 | $ 17,685,330 | $ 20,208,092 |
| Revenue Over/(Under) Expense | $ 600,798 | $ 4,796,952 | $ 20,843,189 | $ 25,224,814 |
| EBITDA | $ 2,835,133 | $ 4,497,195 | $ 29,452,841 | $ 31,500,487 |
| Patient Cash Collected | $ 18,920,140 | $ 17,720,977 | $ 239,372,362 | $ 229,104,209 |
| Cash and Cash Equivalents | $ 13,310,208 | $ 24,610,432 | $ 13,310,208 | $ 24,610,432 |
| Net Working Capital | $ 7,910,369 | $ 21,049,393 | $ 7,910,369 | $ 21,049,393 |
| Unrestricted Assets | $ 25,882,585 | $ 27,668,208 | $ 25,882,585 | $ 27,668,208 |
| Credit Ratings (S&P, FITCH and Moody's) | Ba2 | Ba2 | Ba2 | Ba2 |

Exhibit 17
Financial Worksheets

The key assumptions used in Trinity Health- New England, Inc. financial worksheets include the following:

- FY 2015 amounts represent unaudited financial results as of September 30, 2105
- FY 2016 is Trinity Health – New England's revised budget which includes cost reductions as a result of the reduction in the State's supplemental payments.
- Inpatient volume for FY 2016 is projected to be flat with slight decreases in volume in 2017, 2018 and 2019 as a result of decreased utilization of inpatient services as we shift to population health. This overall projected decrease is offset by a slight increase in utilization in the Connecticut Joint Replacement Service line.
- Slight growth in hospital outpatient visits is expected and the projections include increases of .1%, .1% and .2% respectively in 2016 through 2019.
- The projected amounts include an expectation that Saint Francis *Care* will begin to assume risk contracts in FY 2016 and receive per member per month payments to cover the healthcare costs.
- Projected salary expenses include increases of 3.7%, 1.1%, 2.3% and 3.5%, respectively, in 2016 through 2019. This projection anticipates an increase in the number of employees as well as an inflation increase.
- Supplies and other expenses remain flat in FY 2016 and 2017 and slight increases are expected in 2018 and 2019.
- Decrease in interest expense is the result of the restructure of outstanding debt as of October 1 to an intercompany loan with Trinity Health.

The financial projections for FY 2016-2019 do not include potential synergies to be realized as a result of the recent approved transaction between Trinity Health and Trinity Health-New England effective October 1, 2015.

**Trinity Health - New England, Inc.** **NON-PROFIT**

**Applicant:**

**Financial Worksheet (A)**

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

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **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 | $ 2,433,797 | $ 2,577,924 | $ 224,093 | $ 2,802,017 | $ 2,796,713 | $ 917,519 | $ 3,714,232 | $ 2,992,483 | $ 963,395 | $ 3,955,878 | $ 3,201,957 | $ 1,011,565 | $ 4,213,522 |
| 2 | Less: Allowances | 1,597,426 | 1,713,039 | 144,509 | 1,857,548 | 1,919,493 | 592,210 | 2,511,703 | 2,096,555 | 628,335 | 2,724,890 | 2,278,861 | 666,663 | 2,945,524 |
| 3 | Less: Charity Care | 14,330 | 15,761 | 1,257 | 17,018 | 16,076 | 2,625 | 18,701 | 16,398 | 2,756 | 19,154 | 16,726 | 2,894 | 19,620 |
| 4 | Less: Other Deductions | 23,689 | 32,203 | 225 | 32,428 | 32,203 | 9,746 | 41,949 | 32,203 | 9,746 | 41,949 | 32,203 | 9,746 | 41,949 |
| | **Net Patient Service Revenue** | **$ 798,352** | **$ 816,921** | **$ 78,102** | **$ 895,023** | **$ 828,941** | **$ 312,938** | **$ 1,141,879** | **$847,327** | **$ 322,558** | **$ 1,169,885** | **$874,167** | **$ 332,262** | **$1,206,429** |
| 5 | Medicare | 306,149 | 304,839 | 32,217 | 337,056 | 323,804 | 127,442 | 451,246 | 328,423 | 130,173 | 458,596 | 331,579 | 132,837 | 464,416 |
| 6 | Medicaid | 100,599 | 83,178 | 12,973 | 96,151 | 86,713 | 51,391 | 138,104 | 87,119 | 51,470 | 138,589 | 87,611 | 51,492 | 139,103 |
| 7 | CHAMPUS & TriCare | 1,288 | 1,087 | 78 | 1,165 | 1,135 | 268 | 1,403 | 1,168 | 271 | 1,439 | 1,181 | 274 | 1,455 |
| 8 | Other | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | **Total Government** | **$408,036** | **$389,104** | **$45,268** | **$434,372** | **$411,652** | **$179,101** | **$590,753** | **$416,710** | **$181,914** | **$598,624** | **$420,371** | **$184,603** | **$604,974** |
| 9 | Commercial Insurers | 356,086 | 397,560 | 29,757 | 427,317 | 391,492 | 121,554 | 513,046 | 405,320 | 127,811 | 533,131 | 429,198 | 134,262 | 563,460 |
| 10 | Uninsured | 22,159 | 17,934 | 195 | 18,129 | 16,141 | 736 | 16,877 | 15,334 | 744 | 16,078 | 14,567 | 751 | 15,318 |
| 11 | Self Pay | - | - | | - | - | - | - | - | - | - | - | - | - |
| 12 | Workers Compensation | 12,071 | 12,324 | 2,499 | 14,823 | 9,656 | 10,250 | 19,906 | 9,963 | 10,778 | 20,741 | 10,031 | 11,322 | 21,353 |
| 13 | Other | - | - | 383 | 383 | - | 1,297 | 1,297 | - | 1,311 | 1,311 | - | 1,324 | 1,324 |
| | **Total Non-Government** | **$ 390,316** | **$ 427,818** | **$ 32,834** | **$ 460,652** | **$ 417,289** | **$ 133,837** | **$ 551,126** | **$430,617** | **$ 140,644** | **$ 571,261** | **$453,796** | **$ 147,659** | **$601,455** |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | **$ 798,352** | **$ 816,922** | **$ 78,102** | **$ 895,024** | **$ 828,941** | **$ 312,938** | **$ 1,141,879** | **$847,327** | **$ 322,558** | **$ 1,169,885** | **$874,167** | **$ 332,262** | **$1,206,429** |
| 14 | Less: Provision for Bad Debts | 25,600 | 27,828 | 2,522 | **30,350** | 24,220 | 10,490 | **34,710** | $22,817 | 11,014 | **33,831** | $21,200 | 11,565 | **$32,765** |
| | **Net Patient Service Revenue less provision for bad debts** | **$ 772,752** | **$ 789,093** | **$ 75,580** | **$ 864,673** | **$ 804,721** | **$ 302,449** | **$ 1,107,170** | **$824,510** | **$ 311,544** | **$ 1,136,054** | **$852,967** | **$ 320,697** | **$1,173,664** |
| 15 | Other Operating Revenue | 39,526 | 40,570 | 1,936 | **42,506** | 42,000 | 7,253 | **49,253** | 43,100 | 7,253 | **50,353** | 44,300 | 7,253 | **51,553** |
| 17 | Net Assets Released from Restrictions | 10,904 | 10,212 | - | **10,212** | 9,400 | 733 | **10,133** | 9,400 | 733 | **10,133** | 9,500 | 733 | **10,233** |
| | **TOTAL OPERATING REVENUE** | **$823,182** | **$839,875** | **$77,516** | **$917,391** | **$856,121** | **$310,435** | **$1,166,556** | **$877,010** | **$319,530** | **$1,196,540** | **$906,767** | **$328,683** | **$1,235,450** |
| **B.** | **OPERATING EXPENSES** | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $ 378,047 | $ 392,253 | $ 33,702 | $ 425,955 | $ 396,501 | $ 136,251 | $ 532,752 | $ 405,935 | $ 139,657 | $ 545,592 | $ 420,297 | $ 143,149 | $ 563,446 |
| 2 | Fringe Benefits | 86,980 | 93,031 | 7,579 | 100,610 | 97,757 | 31,367 | 129,124 | 100,722 | 32,151 | 132,873 | 104,543 | 32,955 | 137,498 |
| 3 | Physicians Fees | 24,837 | 25,805 | 2,900 | 28,705 | 26,321 | 11,362 | 37,683 | 26,847 | 11,703 | 38,550 | 27,652 | 12,054 | 39,706 |
| 4 | Supplies and Drugs | 128,031 | 128,006 | 11,799 | 139,805 | 125,387 | 50,720 | 176,107 | 128,259 | 52,500 | 180,759 | 131,465 | 55,125 | 186,590 |
| 5 | Depreciation and Amortization | 39,696 | 39,743 | 2,919 | 42,662 | 42,891 | 12,064 | 54,955 | 45,164 | 12,426 | 57,590 | 47,422 | 12,799 | 60,221 |
| 6 | Provision for Bad Debts-Other[b] | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 7 | Interest Expense | 11,152 | 10,950 | 58 | 11,008 | 10,427 | 219 | 10,646 | 10,140 | 208 | 10,348 | 9,861 | 198 | 10,059 |
| 8 | Malpractice Insurance Cost | 6,910 | 12,831 | 1,479 | 14,310 | 13,088 | 6,035 | 19,123 | 13,349 | 6,156 | 19,505 | 13,683 | 6,279 | 19,962 |
| 9 | Lease Expense | 9,883 | 11,084 | - | 11,084 | 11,305 | - | 11,305 | 11,532 | - | 11,532 | 11,820 | - | 11,820 |
| 10 | Other Operating Expenses | 130,060 | 123,920 | 14,180 | 138,100 | 119,222 | 55,944 | 175,166 | 118,759 | 56,275 | 175,034 | 121,814 | 57,401 | 179,215 |
| | **TOTAL OPERATING EXPENSES** | **$ 815,596** | **$ 837,623** | **$ 74,616** | **$ 912,239** | **$ 842,899** | **$ 303,963** | **$ 1,146,862** | **$ 860,707** | **$ 311,078** | **$ 1,171,785** | **$888,557** | **$ 319,960** | **$1,208,517** |
| | | **$ 350,569** | **$ 352,339** | | | **$ 348,641** | | | **$ 354,050** | | | **$ 363,717** | | |
| | **INCOME/(LOSS) FROM OPERATIONS** | **$ 7,586** | **$ 2,252** | **$ 2,900** | **$ 5,152** | **$ 13,222** | **$ 6,472** | **$ 19,694** | **$ 16,303** | **$ 8,453** | **$ 24,756** | **$18,210** | **$ 8,723** | **$26,933** |
| | **NON-OPERATING REVENUE** | (21,308) | - | **652** | **652** | **-** | **2,963** | **2,963** | **-** | **3,052** | **3,052** | **$0** | **3,144** | **$3,144** |
| | **EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES** | **$ (13,722)** | **$ 2,252** | **$ 3,552** | **$ 5,804** | **$ 13,222** | **$ 9,435** | **$ 22,657** | **$ 16,303** | **$ 11,505** | **$ 27,808** | **$18,210** | **$ 11,867** | **$30,077** |
| | Principal Payments | **$8,785** | **$8,172** | $0 | **$8,172** | **$7,673** | $3,000 | **$10,673** | **$6,271** | $3,000 | **$9,271** | **$6,539** | $3,000 | **$9,539** |

**Trinity Health - New England, Inc.** **NON-PROFIT**

**Applicant:**

**Financial Worksheet (A)**

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

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **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.** | **PROFITABILITY SUMMARY** | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | **0.9%** | **0.3%** | **3.7%** | **0.6%** | **1.5%** | **2.1%** | **1.7%** | **1.9%** | **2.6%** | **2.1%** | **2.0%** | **2.6%** | **2.2%** |
| 2 | Hospital Non Operating Margin | **-2.7%** | **0.0%** | **0.8%** | **0.1%** | **0.0%** | **0.9%** | **0.3%** | **0.0%** | **0.9%** | **0.3%** | **0.0%** | **0.9%** | **0.3%** |
| 3 | Hospital Total Margin | **-1.7%** | **0.3%** | **4.5%** | **0.6%** | **1.5%** | **3.0%** | **1.9%** | **1.9%** | **3.6%** | **2.3%** | **2.0%** | **3.6%** | **2.4%** |
| **D.** | **FTEs** | **4,774.7** | **4,838.0** | **438.5** | **5,276.5** | **4,791.9** | **1,797.1** | **6,589.0** | **4,815.9** | **1,797.1** | **6,613.0** | **4,841.9** | **1,797.1** | **6,639.0** |
| **E.** | **VOLUME STATISTICS[c]** | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 32,337 | 33,071 | 2,925 | **35,996** | 32,316 | 11,816 | **44,132** | 32,408 | 11,757 | **44,165** | 32,250 | 11,698 | **43,948** |
| 2 | Outpatient Visits | 1,040,563 | 1,056,955 | 64,093 | **1,121,048** | 1,075,133 | 251,543 | **1,326,676** | 1,093,645 | 256,574 | **1,350,219** | 1,112,497 | 261,706 | **1,374,203** |
| | **TOTAL VOLUME** | **1,072,900** | **1,090,026** | **67,018** | **1,157,044** | **1,107,449** | **263,359** | **1,370,808** | **1,126,053** | **268,331** | **1,394,384** | **1,144,747** | **273,404** | **1,418,151** |

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

**Applicant:** **Saint Francis Hospital and Medical Center (without affiliates and subsidiaries)** **NON-PROFIT**

**Financial Worksheet (A)**

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

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LINE | Total Entity: | FY 2015 | FY 2016 | FY 2016 | FY 2016 | FY 2017 | FY 2017 | FY 2017 | FY 2018 | FY 2018 | FY 2018 | FY 2019 | FY 2019 | FY 2019 |
| | | 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 | $ 2,104,370 | $ 2,183,919 | $ - | $ 2,183,919 | $ 2,336,793 | $ - | $ 2,336,793 | $ 2,500,369 | $ - | $ 2,500,369 | $ 2,675,395 | $ - | $ 2,675,395 |
| 2 | Less: Allowances | 1,396,910 | 1,466,182 | - | 1,466,182 | 1,601,089 | - | 1,601,089 | 1,749,382 | - | 1,749,382 | 1,900,716 | - | 1,900,716 |
| 3 | Less: Charity Care | 13,559 | 13,796 | - | 13,796 | 14,072 | - | 14,072 | 14,353 | - | 14,353 | 14,640 | - | 14,640 |
| 4 | Less: Other Deductions | 23,689 | 32,203 | - | 32,203 | 32,203 | - | 32,203 | 32,203 | - | 32,203 | 32,203 | - | 32,203 |
| | **Net Patient Service Revenue** | **$ 670,212** | **$ 671,738** | **$ -** | **$ 671,738** | **$ 689,429** | **$ -** | **$ 689,429** | **$ 704,431** | **$ -** | **$ 704,431** | **$727,836** | **$ -** | **$727,836** |
| 5 | Medicare | 264,123 | 255,713 | - | 255,713 | 274,505 | - | 274,505 | 278,138 | - | 278,138 | 280,289 | - | 280,289 |
| 6 | Medicaid | 83,037 | 64,842 | - | 64,842 | 67,839 | - | 67,839 | 67,868 | - | 67,868 | 67,976 | - | 67,976 |
| 7 | CHAMPUS & TriCare | 1,147 | 909 | - | 909 | 945 | - | 945 | 974 | - | 974 | 982 | - | 982 |
| 8 | Other | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | **Total Government** | **$348,307** | **$321,464** | **$ -** | **$321,464** | **$343,289** | **$ -** | **$343,289** | **$346,980** | **$ -** | **$346,980** | **$349,247** | **$ -** | **$349,247** |
| 9 | Commercial Insurers | 295,682 | 323,052 | - | 323,052 | 323,108 | - | 323,108 | 334,808 | - | 334,808 | 356,539 | - | 356,539 |
| 10 | Uninsured | 15,510 | 15,280 | - | 15,280 | 13,752 | - | 13,752 | 13,064 | - | 13,064 | 12,411 | - | 12,411 |
| 11 | Self Pay | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 12 | Workers Compensation | 10,713 | 11,942 | - | 11,942 | 9,280 | - | 9,280 | 9,579 | - | 9,579 | 9,639 | - | 9,639 |
| 13 | Other | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | **Total Non-Government** | **$ 321,905** | **$ 350,274** | **$ -** | **$ 350,274** | **$ 346,140** | **$ -** | **$ 346,140** | **$ 357,451** | **$ -** | **$ 357,451** | **$378,589** | **$ -** | **$378,589** |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | **$ 670,212** | **$ 671,738** | **$ -** | **$ 671,738** | **$ 689,429** | **$ -** | **$ 689,429** | **$ 704,431** | **$ -** | **$ 704,431** | **$727,836** | **$ -** | **$727,836** |
| 14 | Less: Provision for Bad Debts | 20,981 | 23,320 | - | **23,320** | 20,400 | - | **20,400** | 19,000 | - | **19,000** | 17,300 | - | **$17,300** |
| | **Net Patient Service Revenue less provision for bad debts** | **$ 649,231** | **$ 648,418** | **$ -** | **$ 648,418** | **$ 669,029** | **$ -** | **$ 669,029** | **$ 685,431** | **$ -** | **$ 685,431** | **$710,536** | **$ -** | **$710,536** |
| 15 | Other Operating Revenue | 31,260 | 29,397 | - | **29,397** | 29,985 | - | **29,985** | 30,585 | - | **30,585** | 31,197 | - | **31,197** |
| 17 | Net Assets Released from Restrictions | 4,156 | 3,647 | - | **3,647** | 3,720 | - | **3,720** | 3,794 | - | **3,794** | 3,870 | - | **3,870** |
| | **TOTAL OPERATING REVENUE** | **$684,647** | **$681,462** | **$0** | **$681,462** | **$702,734** | **$0** | **$702,734** | **$719,810** | **$0** | **$719,810** | **$745,603** | **$0** | **$745,603** |
| B. | OPERATING EXPENSES | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $ 257,621 | $ 256,489 | $ - | $ 256,489 | $ 268,882 | $ - | $ 268,882 | $ 275,833 | $ - | $ 275,833 | $ 285,292 | $ - | $ 285,292 |
| 2 | Fringe Benefits | 68,083 | 71,139 | - | 71,139 | 78,965 | - | 78,965 | 81,344 | - | 81,344 | 83,784 | - | 83,784 |
| 3 | Physicians Fees | 44,673 | 47,053 | - | 47,053 | 47,994 | - | 47,994 | 48,954 | - | 48,954 | 50,423 | - | 50,423 |
| 4 | Supplies and Drugs | 106,637 | 105,873 | - | 105,873 | 105,032 | - | 105,032 | 107,445 | - | 107,445 | 110,132 | - | 110,132 |
| 5 | Depreciation and Amortization | 37,714 | 37,700 | - | 37,700 | 40,581 | - | 40,581 | 42,734 | - | 42,734 | 44,871 | - | 44,871 |
| 6 | Provision for Bad Debts-Other[b] | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 7 | Interest Expense | 11,620 | 10,950 | - | 10,950 | 10,427 | - | 10,427 | 10,140 | - | 10,140 | 9,861 | - | 9,861 |
| 8 | Malpractice Insurance Cost | 10,303 | 10,333 | - | 10,333 | 10,539 | - | 10,539 | 10,750 | - | 10,750 | 11,019 | - | 11,019 |
| 9 | Lease Expense | 7,134 | 7,047 | - | 7,047 | 7,188 | - | 7,188 | 7,331 | - | 7,331 | 7,515 | - | 7,515 |
| 10 | Other Operating Expenses | 138,217 | 135,863 | - | 135,863 | 126,592 | - | 126,592 | 126,980 | - | 126,980 | 130,226 | - | 130,226 |
| | **TOTAL OPERATING EXPENSES** | **$ 682,002** | **$ 682,447** | **$ -** | **$ 682,447** | **$ 696,200** | **$ -** | **$ 696,200** | **$ 711,511** | **$ -** | **$ 711,511** | **$733,123** | **$ -** | **$733,123** |
| | **INCOME/(LOSS) FROM OPERATIONS** | **$ 2,645** | **$ (985)** | **$ -** | **$ (985)** | **$ 6,534** | **$ -** | **$ 6,534** | **$ 8,299** | **$ -** | **$ 8,299** | **$12,480** | **$ -** | **$12,480** |
| | **NON-OPERATING REVENUE** | (20,060) | - | - | - | - | - | - | - | - | - | **$0** | - | **$0** |
| | **EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES** | **$ (17,415)** | **$ (985)** | **$ -** | **$ (985)** | **$ 6,534** | **$ -** | **$ 6,534** | **$ 8,299** | **$ -** | **$ 8,299** | **$12,480** | **$ -** | **$12,480** |
| | Principal Payments | **$8,785** | **$8,172** | $0 | **$8,172** | **$7,673** | $0 | **$7,673** | **$6,271** | $0 | **$6,271** | **$6,539** | $0 | **$6,539** |

**Saint Francis Hospital and Medical Center (without affiliates and subsidiaries)** **NON-PROFIT**

**Applicant:**

**Financial Worksheet (A)**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **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.** | **PROFITABILITY SUMMARY** | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | **0.4%** | **-0.1%** | **0.0%** | **-0.1%** | **0.9%** | **0.0%** | **0.9%** | **1.2%** | **0.0%** | **1.2%** | **1.7%** | **0.0%** | **1.7%** |
| 2 | Hospital Non Operating Margin | **-3.0%** | **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 | **-2.6%** | **-0.1%** | **0.0%** | **-0.1%** | **0.9%** | **0.0%** | **0.9%** | **1.2%** | **0.0%** | **1.2%** | **1.7%** | **0.0%** | **1.7%** |
| **D.** | **FTEs** | **3,684.8** | **3,616.7** | **0.0** | **3,616.7** | **3,699.0** | **0.0** | **3,699.0** | **3,702.0** | **0.0** | **3,702.0** | **3,718.0** | **0.0** | **3,718.0** |
| **E.** | **VOLUME STATISTICS[c]** | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 31,632 | 32,188 | - | **32,188** | 31,557 | - | **31,557** | 31,649 | - | **31,649** | 31,491 | - | **31,491** |
| 2 | Outpatient Visits | 294,633 | 296,106 | 0 | **296,106** | 299,067 | 0 | **299,067** | 302,058 | | **302,058** | 305,078 | 0 | **305,078** |
| | **TOTAL VOLUME** | **326,265** | **328,294** | **0** | **328,294** | **330,624** | **0** | **330,624** | **333,707** | **0** | **333,707** | **336,569** | **0** | **336,569** |

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Exhibit 17 Financial Statistics

Trinity Health - New England

| Monthly Financial Measurement/Indicators | September 15 YTD | September 14 YTD | September 15 MTD | September 14 MTD | Comments |
|---|---|---|---|---|---|
| **A. Operating Performance:** | | | | | |
| Operating Margin | 0.9% | 1.3% | (5.5%) | 7.8% | operating income/operating revenues |
| Non-Operating Margin | NA | NA | NA | NA | |
| Total Margin | 7.1% | 7.4% | 1.0% | 13.8% | Operating cash flow margin (EBIDA/operating revenue) |
| Bad Debt as % of Gross Revenue | 1.1% | 1.2% | 0.4% | 0.8% | bad debt/total patient serv. Revenue(before allowances) |
| **B. Liquidity:** | | | | | |
| Current Ratio | 2.0 | 2.1 | 2.0 | 2.1 | current assets/current liabilites |
| Days Cash on Hand | NA | NA | NA | NA | See SFH for Reported DCOH measurement |
| Days in Net Accounts Receivables | 36.6 | 40.9 | 36.6 | 40.9 | net ar/net patient ser rev/days in yr |
| Average Payment Period | 57.9 | 57.4 | 57.9 | 57.4 | current liabilities/(total exp-depr)/YTD days in yr |
| **C. Leverage and Capital Structure:** | | | | | |
| Long-term Debt to Equity | 134.9% | 113.9% | 134.9% | 113.9% | total debt/total equity(net assets) |
| Long-term Debt to Capitalization | 57.4% | 53.3% | 57.4% | 53.3% | LTD/LTD+net assets |
| Unrestricted Cash to Debt | 71.7% | 67.2% | 71.7% | 67.2% | cash =DCOH calc |
| Times Interest Earned Ratio | 1.7 | 1.9 | (2.9) | 7.0 | EBIT/Interest expense |
| Debt Service Coverage Ratio | 2.9x* | 2.7x** | 2.9x* | 2.7x** | quarter end (use Jun)/ same as SFHMC reported for DSC measurement |
| Equity Financing Ratio | 20.8% | 25.2% | 20.8% | 25.2% | Net assets/total assets |
| **D. Additional Statistics** | | | | | |
| Income(Loss) from Operations | 7,585,990 | 10,367,192 | (3,651,235) | 5,514,737 | Net income(loss) from operations |
| Revenue Over/(Under) Expense | (13,722,368) | 12,724,139 | (15,314,845) | 4,270,976 | Net gain(loss) |
| EBITDA | 58,433,786 | 59,874,237 | 672,529 | 9,757,223 | based on net income(loss) from operations |
| Patient Cash Collected | NA | NA | NA | NA | |
| Cash and Cash Equivalents | 102,071,359 | 93,155,487 | 102,071,359 | 93,155,487 | from cons bs |
| Net Working Capital | 120,191,181 | 125,356,264 | 120,191,181 | 125,356,264 | current assets-current liabilities |
| Unrestricted Assets | 101,674,917 | 137,311,648 | 101,674,917 | 137,311,648 | from cons bs |

*Measurement data is Sept 30, 2015

**Measurement data is Sept 30,2014

Exhibit 17 Financial Statistics

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Saint Francis Hospital and Medical Center (unaudited)

| Monthly Financial Measurement/Indicators | September 15 YTD | September 14 YTD | September 15 MTD | September 14 MTD | Comments |
|---|---|---|---|---|---|
| **A. Operating Performance:** | | | | | |
| Operating Margin | 0.4% | 2.1% | -10.3% | 3.3% | operating income/operating revenues |
| Non-Operating Margin | NA | NA | NA | NA | |
| Total Margin | 7.6% | 9.1% | -2.7% | 10.1% | Operating cash flow margin (EBIDA/operating revenue) |
| Bad Debt as % of Gross Revenue | 1.0% | 1.1% | 0.01% | 0.7% | bad debt/total patient serv. Revenue(before allowances) |
| **B. Liquidity:** | | | | | |
| Current Ratio | 1.9 | 2.0 | 1.9 | 2.0 | current assets/current liabilites |
| Days Cash on Hand | 89* | 89** | 89* | 89** | quarter end |
| Days in Net Accounts Receivables | 36.7 | 39.9 | 36.7 | 39.9 | net ar/net patient ser rev/days in yr |
| Average Payment Period | 54.4 | 56.3 | 54.4 | 56.3 | current liabilities/(total exp-depr)/YTD days in yr |
| **C. Leverage and Capital Structure:** | | | | | |
| Long-term Debt to Equity | 188.1% | 138.4% | 188.1% | 138.4% | total debt/total equity(net assets) |
| Long-term Debt to Capitalization | 65.3% | 58.1% | 65.3% | 58.1% | LTD/LTD+net assets |
| Unrestricted Cash to Debt | 64.0% | 60.8% | 64.0% | 60.8% | as calculated monthly |
| Times Interest Earned Ratio | 1.3 | 2.2 | -4.9 | 3.1 | EBIT/Interest expense |
| Debt Service Coverage Ratio | 2.9x* | 2.7x** | 3.8x* | 2.7x** | quarter end (use jun) |
| Equity Financing Ratio | 17.3% | 23.3% | 17.3% | 23.3% | Net assets/total assets |
| **D. Additional Statistics** | | | | | |
| Income(Loss) from Operations | 2,884,906 | 14,421,395 | (5,557,203) | 1,893,738 | Net income(loss) from operations |
| Revenue Over/(Under) Expense | (17,175,330) | 15,620,119 | (16,763,738) | 1,267,802 | Net gain(loss) |
| EBITDA | 51,750,212 | 61,840,788 | (1,433,534) | 5,860,101 | based on net income(loss) from operations |
| Patient Cash Collected | NA | NA | NA | NA | |
| Cash and Cash Equivalents | 76,693,459 | 70,506,821 | 76,693,459 | 70,506,821 | from cons bs |
| Net Working Capital | 83,760,221 | 100,331,512 | 83,760,221 | 100,331,512 | current assets-current liabilities |
| Unrestricted Assets | 52,170,274 | 100,019,901 | 52,170,274 | 100,019,901 | from cons bs or rollforward |

*Measurement data is Sept 30, 2015
**Measurement data is Sept 30,2014

Saint Francis Hospital and Medical Center

| | September 15 YTD | September 14 YTD | |
|---|---|---|---|
| **D. Additional Statistics** | | | |
| Income(Loss) from Operations | 2,884,906 | 14,421,395 | Operating expenses increased $15M due to costs of medical supplies and drugs and professional fees for EPIC support, merger due diligence and nurse registry fees. |
| Revenue Over/(Under) Expense | (17,175,330) | 15,620,119 | Due to decrease in investment activity of ($6.2M), $3.6M in 2014 vs. ($2.5M) in 2015. Variance in swap activity of ($16.8M). |
| EBITDA | 51,750,212 | 61,840,788 | Operating expenses increased $15M due to costs of medical supplies and drugs and professional fees for EPIC support, merger due diligence and nurse registry fees. |
| Patient Cash Collected | NA | NA | |
| Cash and Cash Equivalents | 76,693,459 | 70,506,821 | Decrease in a/r patient ($5.7), Increase in a/p $3.7M. Intercompany paydown of receivable $10M. |
| Net Working Capital | 83,760,221 | 100,331,512 | Decrease in a/r patient ($5.7), Increase in a/p $3.7M. |
| Unrestricted Assets | 52,170,274 | 100,019,901 | Due to decrease in investment activity of ($6.2M), $3.6M in 2014 vs. ($2.5M) in 2015. Variance in swap activity of ($17.5M). Pension funding and post retirement liability of ($18M), transfer to affiliate ($14M). |

# EXHIBIT 18

# Saint Mary's
## HOSPITAL

*Office of the President*
*Chad W. Wable, FACHE*

December 19, 2013

Mr. George C. Jepsen
Attorney General
State of Connecticut
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Re: Response to Request for Information – Disclosure of Facility Fees

Dear Mr. Jepsen:

Enclosed are answers to the questions you sent on November 19, 2013 regarding disclosure of facility fees for off-campus hospital-based providers.

If you have additional questions, please feel free to reach out to me or to Silvia Hutcheson, Director of Strategic Planning and Business Development at Saint Mary's Hospital. Silvia can be reached at (203) 709-3312.

I look forward to working with you further on providing meaningful transparency and cost information to consumers during this time of healthcare transformation.

Sincerely,

Chad W. Wable, FACHE
President and Chief Executive Officer

Enclosures

cc: Robert J. Anthony, Esq., Brown Rudnick, LLC
Silvia Hutcheson, Saint Mary's Hospital
James Iacobellis, Connecticut Hospital Association

Saint Mary's
HOSPITAL

# Request for Information: Disclosure of Facility Fees

Submitted by Saint Mary's Hospital
December 19, 2013

1. *Please provide the name, address, specialty type and contact information for each of your off-campus hospital-based providers that currently charges a facility fee.*

**Ambulatory Surgery**

Name: Saint Mary's Naugatuck Valley Surgical Center
Address: 160 Robbins Street, Waterbury, CT 06708
Specialty: Ambulatory Surgery
Contact Information: The phone number is (203) 755-6663.

**Cardiac Testing**

Name: Saint Mary's Cardiovascular Diagnostic Center
Address: 1320 West Main Street, Waterbury, CT 06708
Specialty: Imaging Services (Nuclear Medicine and Carotid Ultrasound) and Cardiac Testing (Echocardiography, Holter Monitoring, and Stress Testing)
Contact Information: The phone number is (203) 709-4506.

**Imaging Services**

Name: Saint Mary's Medical Imaging Center
Address: 475 Chase Parkway, Waterbury, CT 06708
Specialty: Imaging Services (Outpatient MRI)
Contact Information: The telephone number is (203) 709-5550.

**Urgent Care (Two Locations)**

First Location
Name: Saint Mary's Naugatuck Urgent Care Center
Address: 799 New Haven Road, Crosspointe Plaza, Naugatuck, CT 06770
Specialty: Urgent Care, Laboratory, and Imaging Services (X-Ray)
Contact Information: The telephone number is (203) 723-5636.

Second Location
Name: Saint Mary's Wolcott Urgent Care Center
Address: 503 Wolcott Road, Wolcott, CT 06716
Specialty: Urgent Care, Laboratory, and Imaging Services (X-Ray)
Contact Information: The telephone number is (203) 879-7900.

2. *The name and address of each of your off-campus hospital-based provider(s) that currently does not charge a facility fee. For such provider identified, identify the specialty type and state the reason why the provider does not charge a facility fee.*

Franklin Medical Group, PC, which is an affiliate of Saint Mary's Health System, employs Primary Care and Specialty Care healthcare providers. These healthcare providers do not charge facility fees for services. Services are billed through CPT codes at the physician rate. There are fourteen locations in the community. The locations are listed below:

**Location One**
Name: Franklin Medical Group
Address: 133 Scovill Street, Waterbury, CT 06706
Specialties: General Dentistry, Dermatology, General Surgery, Infectious Diseases, Internal Medicine, Oral Surgery, Orthopedics, Psychiatry, and Pulmonary

**Location Two**
Name: Franklin Medical Group
Address: 95 Scovill Street, Waterbury, CT 06706
Specialties: Internal Medicine and Pediatrics

**Location Three**
Name: Franklin Medical Group Behavioral Healthcare Outpatient Services
Address: 100 Jefferson Square, Waterbury, CT 06706
Specialties: Outpatient Behavioral Health Services

**Location Four**
Name: Franklin Medical Group
Address: 1981 East Main Street, Waterbury, CT 06705
Specialties: Internal Medicine

**Location Five**
Name: Franklin Medical Group
Address: 202 Water Street, Naugatuck, CT 06770
Specialties: Internal Medicine

**Location Six**
Name: Franklin Medical Group Primary Care Partners
Address: 166 Waterbury Road, Prospect, CT 06712
Specialty: Primary Care (Internal Medicine, OB/GYN, and Pediatrics), General Surgery, and Breast Surgery

**Location Seven**
Name: Franklin Medical Group Wolcott Internal Medicine
Address: 503 Wolcott Road, First Floor, Wolcott, CT 06716
Specialty: Internal Medicine

**Location Eight**
Name: Franklin Medical Group Breast and Oncology Center
Address: 33 Bullet Hill Road, Suite 214, Southbury, CT 06488
Specialty: General Surgery and Breast Surgery

**Location Nine**
Name: Franklin Medical Group
Address: 1320 West Main Street, Waterbury, CT 06708
Specialty: Cardiology, Pulmonary (Sleep Medicine)

**Location Ten**
Name: Franklin Medical Group
Address: 140 Grandview Avenue, Suite 4, Waterbury, CT 06708
Specialty: Gastroenterology

**Location Eleven**
Name: Franklin Medical Group
Address: 590 Middlebury Road, Suite A, Middlebury, CT 06762
Specialty: General Surgery

**Location Twelve**
Name: Franklin Medical Group
Address: 1389 West Main Street, Waterbury, CT 06708
Specialty: General Surgery

**Location Thirteen**
Name: Franklin Medical Group
Address: 70 Heminway Park Road, Watertown, CT 06795
Specialty: Internal Medicine

**Location Fourteen**
Name: Franklin Medical Group
Address: 56 Franklin Street, Second Floor, Waterbury, CT 06706
Specialty: Cardiology

**Saint Mary's Naugatuck Valley Surgical Center**

3. *For **Saint Mary's Naugatuck Valley Surgical Center**, state whether you require that the provider disclose to patients, in writing:*

   a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

      Patients receive a packet of information in the mail when surgery is scheduled at least two days in advance of the surgery. The packet includes a Patient Letter, a Patient Handbook as well as forms and questionnaires to complete. The Patient Letter is included as Attachment One, and the Patient Handbook is included as Attachment Two. The Patient Letter states that the Naugatuck Valley Surgical Center is an off-site department and is 100% owned by Saint Mary's Hospital. The Patient Handbook states that as an off-site department of the hospital, the surgery center services are charged at the same rate as the hospital.

   b. *That the provider charges separate professional and facility fees:*

      Patients are informed through the Patient Handbook that separate professional fees and facility fees will be charged.

   c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

      An insurance associate informs patients of their co-payment responsibilities in advance of the surgery. The co-payment is collected prior to surgery.

      Patients who receive services that are not covered by insurance are given a Patient Charge Estimate sheet, which is included as Attachment Three.

   d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

      Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

   e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

f. *A statement that the patient's actual liability will depend upon the actual services furnished by the providers:*

All patients sign an Authorization for Treatment, which is Attachment Four. This Authorization for Treatment informs patients that they will receive a hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. *That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.*

The Patient Handbook (Attachment Two) directs patients to contact their insurance carrier with questions.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. *Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?*

The Patient Letter (Attachment One) and the Patient Handbook (Attachment Two) are mailed to patients when their surgery is scheduled at least two days in advance.

Patients who are booked just prior to their surgical date receive the Patient Handbook on the day of surgery. These include patients who are booked on the day of their surgery or the day before their surgery.

All patients sign the Authorization for Treatment (Attachment Four) on the day of surgery.

b. *Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?*

Patients sign the Authorization for Treatment (Attachment Four), which is hand-delivered, when they arrive for surgery.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

   a. *Signage*

      Signage throughout the surgery center includes the Saint Mary's logo and disclosure of 100% ownership by the hospital. A picture of the signage and ownership disclosure is included as Attachment Five.

   b. *Marketing materials*

      The marketing materials, such as the Patient Handbook (Attachment Two), include the Saint Mary's logo.

   c. *Websites;*

      The website includes the Saint Mary's logo and also states that the ambulatory surgery center is a department of Saint Mary's Hospital. The home page of the Naugatuck Valley Surgical Center website is included as Attachment Eight.

   d. *Stationary; and*

      Stationary, such as the Patient Letter (Attachment One), Discharge Instruction Sheets (Attachment Six), and Prescription Pads (Attachment Seven), include the Saint Mary's Hospital logo.

   e. *Other means of disclosure*

      Business cards of Naugatuck Valley Surgical Center employees include the Saint Mary's logo.

**Saint Mary's Cardiovascular Diagnostic Center**

3. *For **Saint Mary's Cardiovascular Diagnostic Center**, state whether you require that the provider disclose to patients, in writing:*

   a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

   Patients sign a Cardiovascular Diagnostic Center Billing Form, which is included as Attachment Nine. Patients sign this form prior to receiving services.

   b. *That the provider charges separate professional and facility fees:*

   The Cardiovascular Diagnostic Center Billing Form states that the provider charges separate professional and facility fees.

   c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

   Patients are given estimates only upon request by the patient or family member.

   d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

   Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

   e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

   Estimates are provided to patients when requested by a patient or family member.

   f. *A statement that the patient's actual liability will depend upon the actual services furnished by the providers:*

   All patients sign an Authorization for Treatment (Attachment Four). This Authorization for Treatment informs patients that they will receive a

hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. *That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.*

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Cardiovascular Diagnostic Center does not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. *Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?*

Written notice is not provided when the appointment is scheduled.

b. *Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?*

Patients sign the Cardiovascular Diagnostic Center Billing Form (Attachment Nine) and the Authorization for Treatment (Attachment Four) on the day of service. Both documents are hand-delivered.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. *Signage*

Signage throughout the Cardiovascular Diagnostic Center includes the Saint Mary's logo. A picture of the Cardiovascular Diagnostic Center signage is included in the brochure, which is Attachment Ten.

b. *Marketing materials*

Marketing materials, such as the Cardiovascular Diagnostic Center Brochure (Attachment Ten), include the Saint Mary's logo.

*c. Websites;*

The Cardiovascular Diagnostic Center does not have a website at this time.

*d. Stationary; and*

Stationary, such as the Cardiovascular Diagnostic Center Billing Form (Attachment Nine) and the Appointment Cards (Attachment Eleven), include the Saint Mary's Hospital logo.

*e. Other means of disclosure*

Not applicable.

**Saint Mary's Medical Imaging Center**

3. *For **Saint Mary's Medical Imaging Center**, state whether you require that the provider disclose to patients, in writing:*

   a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

   Patients sign the Authorization for Treatment (Attachment Four). The Saint Mary's Medical Imaging Center does not provide additional written materials about ownership by the hospital.

   b. *That the provider charges separate professional and facility fees:*

   The Authorization for Treatment (Attachment Four) states that the provider charges separate professional and facility fees.

   c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

   Patients are given estimates only upon request by the patient or family member.

   d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

   Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

   e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

   Estimates are provided to patients when requested by a patient or family member.

   f. *A statement that the patient's actual liability will depend upon the actual services furnished by the providers:*

   All patients sign an Authorization for Treatment (Attachment Four). This Authorization for Treatment informs patients that they will receive a

hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

g. *That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.*

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Saint Mary's Medical Imaging Center does not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

a. *Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?*

Written notice is not provided when the appointment is scheduled.

b. *Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?*

The Authorization for Treatment (Attachment Four) is hand-delivered. Patients sign the Authorization for Treatment on the day of service.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

a. *Signage*

Signage throughout the Medical Imaging Center includes the Saint Mary's logo.

b. *Marketing materials*

Marketing materials include the Saint Mary's logo.

c. *Websites;*

The hospital website lists the Saint Mary's Medical Imaging Center as a hospital service. Attachment Twelve includes the Saint Mary's Hospital webpage on Patient Services.

*d. Stationary; and*

Not applicable.

*e. Other means of disclosure*

Not applicable.

**Saint Mary's Urgent Care Centers**

3. *For **Saint Mary's Urgent Care Centers**, state whether you require that the provider disclose to patients, in writing:*

    a. *That the provider is owned, affiliated or part of a joint venture with your hospital:*

Patients sign two forms when they arrive for service at the Urgent Care Centers. The first form is the Acknowledgement of Disclosure, which is included as Attachment Thirteen. This Acknowledgement of Disclosure states specifically that the center is no longer a "Walk-In" Center (effective November 18, 2012). Patients also sign the Authorization for Treatment (Attachment Four).

    b. *That the provider charges separate professional and facility fees:*

Both forms state that the provider charges separate professional and facility fees.

    c. *The amount that the provider will potentially charge the patient for services to be rendered by the provider, including the amount of any facility fee, and the amount of the professional fee:*

Patients are given estimates only upon request by the patient or family member.

    d. *An explanation that the patient will incur a financial liability for a facility fee that he or she may not incur if the provider were not hospital-based:*

Patients are not informed in writing that they are incurring a facility fee that they may not incur if the provider were not hospital-based.

    e. *An estimate of the amount that the provider will charge the patient for services to be rendered by the provider based on typical or average charges for visits to the facility, including an estimate of the facility fee and the professional fee likely to be charged:*

Estimates are provided to patients when requested by a patient or family member.

*f. A statement that the patient's actual liability will depend upon the actual services furnished by the providers:*

All patients sign an Authorization for Treatment, which is Attachment Four. This Authorization for Treatment informs patients that they will receive a hospital facility bill as well as bills for professional fees provided by independent contractors such as radiologists and pathologists.

*g. That for additional information regarding the provider's charges and fees, including any payments the patient will be required to make, and the location of other providers that may be available to supply comparable services to the patient at a lower cost, any patient enrolled in an insurance or health care plan should contact that plan for more detailed information.*

If questions about insurance coverage come up during the registration process, the registrar tells patients to contact their insurance carrier for additional information. The Urgent Care Centers do not provide this information in writing.

4. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, please produce exemplars of any written notice sent or provided to your patients and specify:*

*a. Whether the written notice is provided when the appointment is scheduled. If not, when is the notice provided? If yes, by what means is the notice communicated (i.e., mail, electronic mail, other)?*

Appointments for Urgent Care services are not scheduled in advance.

*b. Whether the notice is hand-delivered to patients when they arrive at the provider's office to receive non-emergency care?*

The forms are hand-delivered. Patients sign the Authorization for Treatment (Attachment Four) and the Acknowledgement of Disclosure (Attachment Thirteen) on the day of service.

5. *For each off-campus hospital-based provider identified in your answer to Request No. 1 above, state whether you require your off-campus hospital-based provider to identify itself as part of your hospital in the provider's:*

*a. Signage*

Signage throughout the Urgent Care Centers includes the Saint Mary's logo. Attachment Fourteen includes pictures of the signage at the entrance of the Urgent Care Centers.

*b. Marketing materials*

Marketing materials, such as the yellow banner in the lobbies of the Urgent Care Centers, includes the Saint Mary's logo. A picture of these banners is included as Attachment Fifteen.

*c. Websites;*

The hospital website (Attachment Twelve) lists the Saint Mary's Urgent Care Centers as a hospital service.

*d. Stationary; and*

Stationary, such as the letter included as Attachment Sixteen, includes the Saint Mary's logo.

*e. Other means of disclosure*

A sign, which is included as Attachment Seventeen, is in the registration area of the Urgent Care Centers. This sign is another example of how patients are informed that they will receive separate bills for physician services and facility fees.

Saint Mary's
HOSPITAL

# Attachments

Attachment One: Patient Letter
Attachment Two: Patient Handbook
Attachment Three: Patient Charge Estimate
Attachment Four: Authorization for Treatment
Attachment Five: Naugatuck Valley Surgical Center Signage and Ownership Disclosure
Attachment Six: Discharge Instructions
Attachment Seven: Prescription Blanks
Attachment Eight: Naugatuck Valley Surgical Center Website
Attachment Nine: Cardiovascular Diagnostic Center Billing Form
Attachment Ten: Saint Mary's Cardiovascular Diagnostic Center Brochure
Attachment Eleven: Saint Mary's Cardiovascular Diagnostic Center Appointment Card
Attachment Twelve: Saint Mary's Hospital Website on Patient Services
Attachment Thirteen: Acknowledgement of Disclosure
Attachment Fourteen: Urgent Care Center Signage
Attachment Fifteen: Urgent Care Center Banner
Attachment Sixteen: Urgent Care Center Letter
Attachment Seventeen: Urgent Care Center Sign in Registration Area

Dear Patient, Parent or Guardian:

The Naugatuck Valley Surgical Center is dedicated to providing exceptional patient quality care. To assist in obtaining all of the important information we need to know about you, please **completely** fill out the enclosed **"Patient Data Form", "Health Questionnaire" and "Medication Reconciliation"** sheet.

**Please return the completed forms in the enclosed envelope as soon as possible, or Fax to 203-756-9645.**

***If your procedure is within 3 days of the receipt of these forms, please fax or bring the completed forms with you on the day of your procedure.

Preparing for your surgery can make the day of surgery less stressful. A nurse from the surgical center will call you prior to your surgery to review your medical history, notify you of the time of your surgery and give you instructions. Depending on your health history, you may be required to have pre-admission testing performed. You will also be required to have someone drive you home and stay with you for 24 hours after the procedure. **IF YOU WILL NOT BE HOME TO RECEIVE THIS CALL, PLEASE CONTACT THE SURGICAL CENTER BEFORE NOON THE DAY BEFORE YOUR PROCEDURE.** Also, if at any time prior to your surgery you become ill or have any new health problems, please contact your physician and the Surgical Center. Changes in your health may impact your physician's decision to perform your procedure.

**INSURANCE CARDS:** Please bring your insurance cards with you on the day of the surgery. We will also need to copy your driver's license or picture identification.

**INSURANCE CO-PAYS:** You will be responsible for any **"Hospital One Day Surgery"** co-pay required by your insurance company. This is due on the day of the surgery. We will submit all of your NVSC facility charges to your insurance carrier. If there is an outstanding balance, the billing department will send a statement with your balance due. They are also available to set up payment arrangements prior to your procedure. For your convenience, we accept cash, credit cards, debit cards and personal or bank checks. If you elect to place a credit card on file, charges will be applied for the balance due.

**PRE-AUTHORIZATION:** If your insurance company requires pre-authorization, please make sure that your physician takes care of this prior to your procedure.

**PATIENT BILL OF RIGHTS & RESPONSIBILITIES** A copy of the "Patient Bill of Rights and Responsibilities" are included with information on "Your Rights to Make Health Care Decisions".

**OWNERSHIP:** The Naugatuck Valley Surgical Center is an off site department and 100% owned by Saint Mary's Hospital.

**If you have any questions about the information provided or requested, please contact us at (203) 755-6663**



160 Robbins Street • Waterbury, CT 06708 • (203) 755-6663 • FAX (203) 756-9645

## *Directions*

***From the North:***
Take Route 8 South to Exit 33 (Interstate 84 West) and follow directions below.

***From the South:***
Take Route 8 north to Exit 33 (Interstate 84 West) and follow directions below.

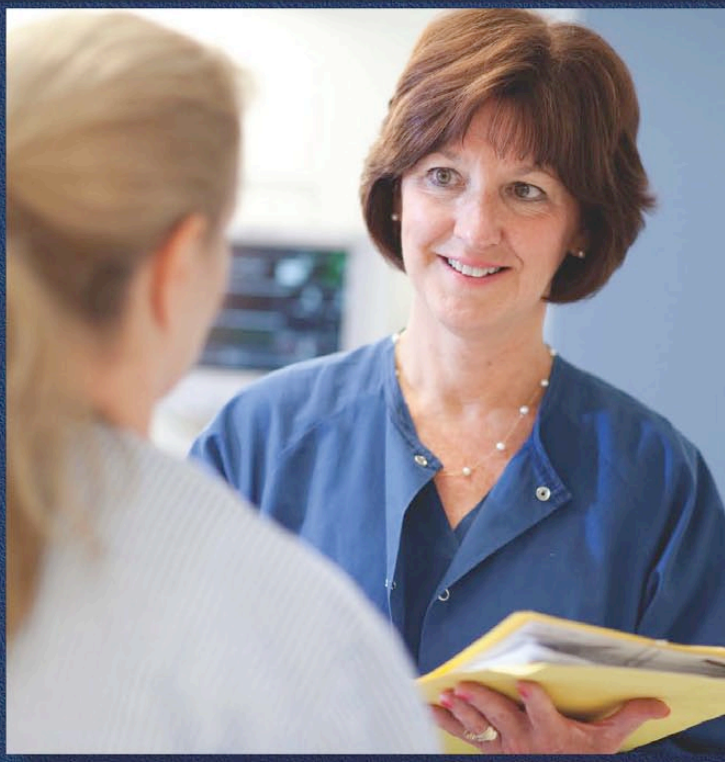
***From the East:***
Take Interstate 84 West to Exit 18. Bear left on the exit ramp for West Main Street. At the end of the exit ramp, turn right onto West Main Street. After the first light, take a left onto Robbins Street. The Naugatuck Valley Surgical Center is .25 miles ahead on the left.

***From the West:***
Take Interstate 84 East to Exit 18 (Chase Parkway). At the end of the exit ramp, turn right onto Chase Parkway. Proceed to light, turn right and cross over the highway. At the next light, turn right onto West Main Street. After the second light, take a left onto Robbins Street. The Naugatuck Valley Surgical Center is .25 miles ahead on the left.

NAUGATUCK VALLEY SURGICAL CENTER
A department of Saint Mary's Hospital

Saint Mary's HOSPITAL
Exceptional care. Every patient. Every day.

160 Robbins Street
Waterbury, CT 06708
**(203) 755-6663**
nvsc.org
info@nvsc.org



# *Patient Handbook*

## *What you need to know before surgery*

NAUGATUCK VALLEY SURGICAL CENTER
A department of Saint Mary's Hospital

Saint Mary's HOSPITAL
Exceptional care. Every patient. Every day.

# *Welcome*

**Betty Bozzuto**
***Vice President***
***Surgical Services***

Welcome to the Naugatuck Valley Surgical Center. As a department of Saint Mary's Hospital, we are committed to providing exceptional care to every patient, every day.

Your surgeon has chosen our surgical center for our skill and our reputation of delivering high quality and individualized care to this community since 1986. Here, your surgeon works with highly qualified anesthesiologists, CRNAs, registered nurses and support staff in a facility equipped with state-of-the-art technology. Our surgical center staff is experienced in gynecology, ophthalmology, orthopedics, gastroenterology, podiatry, otorhinolaryngology (ENT), urology, oral/dental surgery, general surgery, plastic surgery and pain management.

You may be interested to know that over 70% of all surgery is now performed in an outpatient surgical setting similar to this one.

You can expect personalized care – because you are important to us.

### During your stay, you can expect:

- A facility designed exclusively for and specializing in ambulatory surgery
- State-of-the-art operating rooms and post-operative patient care areas
- Individualized, high-quality care given in a warm, friendly setting
- Staff that is fully CPR, ACLS and PALS certified
- Thorough medical staff credentialing and Medical Advisory Board physician peer review
- Licensure by the State and Medicare Certification
- Cost-effective services with the same charge structure as Saint Mary's Hospital

# *Insurance & Billing*

We participate with most local and national insurers, HMOs, PPOs, IPAs and Workers' Compensation carriers. We also participate with Medicare and most Medicaid programs.

For the services rendered at the time of your visit, your insurance company will be billed with the information that you provide for us. As an off-site department of Saint Mary's Hospital, our charges are the same as services at the hospital.

If you have any questions as to whether the Center participates with your insurance carrier, please contact our billing department or your insurance carrier. You are responsible for any deductibles, co-insurance or one day surgery co-pays. Co-pays are due at the time of your visit.

Dental surgery is paid with your hospital insurance, not your dental insurance. Check your coverage with your insurance carrier or employer.

You will receive a bill from Saint Mary's Hospital/ Naugatuck Valley Surgical Center for any balance that is billable to you after your insurance is paid. You will also receive a separate bill from your surgeon, anesthesiologist, pathology and/or radiology departments, depending on which services were utilized when you were a patient at our center.

Patients having non-covered or cosmetic procedures, or uninsured patients, are asked to settle their account before surgery is performed. Our Billing Associate will contact you with an estimate of charges for the procedure that your surgeon has scheduled for you. All charges are estimated and may differ from the estimate if additional or different procedures are performed. The patient is responsible for any additional charges that result. Any unpaid balance will be billed to you, and payment is requested within 30 days of receipt of statement.

### Workers' Compensation

Workers' Compensation claims need additional information. Please make sure that you provide the following information on the "Patient Data" form: Workers' Compensation insurance carrier name and contact person, employer name and address, date and time of injury, and claim number.

# *Your Child & Surgery*

As you might expect, surgery is often frightening to your child, mostly because the surroundings and the experience are unfamiliar. The Surgical Center staff will work with parents to reassure your child and make him/her feel at ease. All questions are important to us, and we encourage you to let us know of any concerns. We care.

### Here is how we can help:

- Call us as soon as surgery is scheduled ***to arrange a personal tour*** for you and your child, if you so desire.
- ***A Surgical Center nurse will call before the day of surgery*** to confirm specific instructions about your child's operation. If you will not be available by phone, please call us the day before surgery, between 8:00 a.m. and 2:00 p.m.
- ***We will not leave your child alone***, not even for a minute. From admitting to recovery, our qualified staff will attend to your child's needs.

### This is how you can help:

- ***Tell your child what to expect.*** Encourage him or her to ask questions. We are happy to discuss any questions your child may have at the time of your tour.
- ***Stay with your child.*** We recognize that a parent's presence is very comforting to a child. You may stay with your child until he/she is taken into the operating room. You will be reunited almost immediately following surgery.
- ***Bring your child's favorite blanket, toy or book.***
- ***Accompany your child under 18 years of age.*** A parent or guardian must remain at the Surgical Center while your child is in our facility. Parents and guardians must sign all consent forms for children under 18.

# *Before Surgery*

Before surgery, ***call your surgeon*** if you have questions or if there is any change in your physical condition. You should call even if you just have a scratchy throat.

***Ask about medication.*** If you take aspirin, medication containing aspirin, diet pills, blood thinners, or herbal supplements on a regular basis, please ask your doctor if and when you should stop taking them prior to your surgery. We may also give you instructions about medications.

***You can expect a call before the day of surgery.*** A Surgical Center nurse will call you to confirm the time of your surgery, review your medical history and give you pre-operative instructions. These instructions are for your benefit, safety and comfort. If you are not available by phone, please call us the day before your surgery, between 8:00 a.m. and 4:00 p.m.

***Each patient must have a history and physical form completed within 30 days of surgery.*** Ask your surgeon if he/she will complete the form, or see your medical doctor. Your surgeon will determine if any lab work is required prior to surgery.

***Do not eat or drink anything — not even gum, hard candy or a glass of water — after midnight the night before your procedure,*** unless otherwise advised by the Surgical Center. Also, children may receive different instructions.

***Arrange for a ride home.*** A responsible person must accompany you home. *You will not be permitted to drive yourself home.*

***Please follow the rules for your safety and comfort.*** If you do not follow these rules, and the rules listed for the day of surgery, we may have to cancel your surgery for safety reasons.

## Day of Surgery

Remember to follow these rules; they are designed for your safety, comfort, and convenience.

***Arrive one hour and 15 minutes before your scheduled operation, unless directed otherwise.*** When you arrive, you will meet your anesthesiologist to discuss the best anesthetic for your surgery. You will also meet your nurses and other members of our staff who will be glad to assist you during your stay.

***Do not eat or drink, including water***, in the morning, unless otherwise advised by the Surgical Center.

***Wear loose-fitting casual clothing*** that you can store in a locked drawer. We will provide a patient gown, bathrobe, and slippers for your surgery.

***Please leave contact lenses at home.*** If you must bring them, bring a storage case and solution.

***All body piercings should be removed.***

***Please leave all jewelry and valuables at home.***

***Do not wear makeup or fingernail polish.***

***Toenail polish should be removed if you are having any foot, knee or other leg surgery.***

***Bring your completed Patient Data Form, Health Questionaire, Medication Reconciliation and insurance forms*** if you have not already mailed them to us.

***Bring your insurance ID card(s) and a photo ID.***

## Following Surgery

After your surgery, you will awaken in the comfortable atmosphere of the Post Anesthesia Care Unit (Recovery Room), where our professional staff will continue to monitor your recovery. Your nurse will encourage you to drink liquids and provide you with a large dose of personal attention.

When your anesthesiologist determines that you're ready to go home, your nurse will review your home care instructions with you and your family.

***You may not drive yourself home.*** Someone must drive you home, as you may feel slightly sleepy or dizzy after anesthesia and medications.

***The next 24 hours are important to your recovery.*** Even though surgery is behind you, you still need to allow time to recover at home.

### Here is what you must do at home:

- ***Have a responsible adult with you and someone to stay home with you for the first 24 hours.***
- ***Do not drive or operate heavy equipment.***
- ***Follow the special instructions that your surgeon or our staff provided.***
- ***Do not take medications without your surgeon's approval.***
- ***Call your surgeon if you have unusual symptoms or changes in your condition that you were not expecting.***
- ***Do not drink any alcoholic beverages.***
- ***Expect to hear from us.*** Your Post Anesthesia Care Unit nurse will call the day after surgery to check your progress and answer any questions.
- ***Pamper yourself*** and avoid strenuous activity. Do not be fooled; you may feel fine immediately following surgery, but this is not the day to overdo it!
- ***Do not sign any legal documents.***

You may also receive a patient questionnaire following surgery. Please fill this form out and return it to us — your response and input means a lot to us.

# *Patient Charge Estimate*

## *for: pt*

**PATIENT NAME:** _____
**PATIENT PHONE:** _____

**PLANNED DOS:**_____

**PHYSICIAN NAME:** _____
**PHYSCIAN PHONE:** _____

**INSURANCE CO:** _____
**INSURANCE PHONE:** _____

**BENEFIT INFO:** _____
_____
_____
_____
_____

**PROPOSED PROCEDURE:**
**CPT CODE:**_____ **FEE:**_____
**CPT CODE:**_____ **FEE:**_____
**CPT CODE:**_____ **FEE:**_____
**ANESTHESIA FEE:** _____ **FEE:**_____

**NOTES:** This estimate is based on the attached booking. This quote is subject to change if the physician changes the procedure.

_____
_____
_____

_____
**pt signature** **date**

***Disclaimer***

***This is an estimate of charges for hospital services only. It is a good faith estimate based on the hospital's current price list, an average of previous procedures performed at Saint Mary's Hospital, and the treatment your physician is ordering for you. It is not legally binding. Your final bill may be more or less than this estimate. If you have overpaid us, we will promptly refund you. If you have not paid us enough, we expect additional payment from you.***

***Denegación***

***El siguiente es un estimado solo por servicios proveidos por el hospital. Es un estimado en buena fe basado en la lista de precios del hospital, un promedio del costo de procedimientos previos del hospital, y de el tratamiento ordenado por su medico. Su cuenta final puede ser mas o menos que la dicha en este estimado. En caso de un sobre pago al hospital, le reembolsaremos el sobrante. En caso de un corto pago, esperamos su saldo inmediato.***

## AUTHORIZATION FOR TREATMENT

I hereby give my consent to the hospitalization and treatment at Saint Mary's Hospital, which adheres to the Catholic Ethical and Religious Directives, encompassing routine Diagnostic testing and/or procedures which may include HIV-related tests, Medical and/or Surgical treatment and whatever Anesthesia deemed necessary by my (His, Her) Physician, His/Her Assistant or Designates. Upon presentation for outpatient services I acknowledge that I am under the care of the referring physician.

## AUTHORIZATION TO RELEASE INFORMATION FOR SUBSEQUENT CARE

The undersigned hereby authorizes Saint Mary's Hospital to release such diagnostic and therapeutic information including any psychiatric, alcohol or drug abuse, and/or confidential HIV related information as may be necessary for referral to any medical practitioner and/or medical facility responsible for my subsequent care.

## DISCLOSURE OF INFORMATION FOR PAYMENT

The undersigned hereby authorizes Saint Mary's Hospital and/or hospital based physicians to release such diagnostic and therapeutic information including any psychiatric, alcohol or drug abuse, and/or confidential HIV related information as may be necessary to determine benefits entitlement and to process payment claims for health care services rendered.

## FINANCIAL RESPONSIBILITY / ASSIGNMENT OF INSURANCE BENEFITS

I agree to pay all charges for services rendered to me between admission and discharge and/or all charges for ambulatory care or outpatient services. I hereby assign payment directly to Saint Mary's Hospital, 56 Franklin Street, Waterbury CT 06706 and/or hospital based physicians of the health insurance benefits otherwise payable to me but not to exceed the regular charges for this period of hospitalization and/or outpatient treatment. I understand that I will be responsible for charges not covered by my health insurance plan, which may include but is not limited to all co- payments, deductibles and non-covered services such as cosmetic surgery. I further agree that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed to Saint Mary's Hospital and/or hospital based physicians by myself or my family. If I am uninsured or otherwise unable to pay my medical bill, I understand that I can request to speak with a financial counselor to determine my eligibility for available financial assistance. **Please note: If you receive care from physician independent contractors and/or hospital based physicians such as anesthesiologists, radiologists, pathologists, or other physicians, you will receive a separate bill directly from them in addition to a hospital facility bill.**

## SERVICES PROVIDED BY INDEPENDENT CONTRACTORS

I acknowledge and understand that the Anesthesia, Emergency, Radiology and Pathology services that I may receive at Saint Mary's Hospital will be provided by physicians who are self-employed, independent contractors. Saint Mary's Hospital does not control, and is not responsible for, the judgment or conduct of these physicians, and they are not agents, servants, or employees of Saint Mary's Hospital. I also acknowledge that private attending physicians, and the consultants to whom they may refer my care and treatment, are also not agents, servants or employees of Saint Mary's Hospital, and Saint Mary's Hospital does not control, and is not responsible for, the judgment or conduct of these physicians.

PATIENT SIGNATURE (OR LEGAL REPRESENTATIVE) _____ DATE AND TIME _____ RELATIONSHIP _____

PATIENT UNABLE TO SIGN (INDICATE REASON) _____

WITNESSED BY _____ DATE AND TIME _____

NOTE: Parental consent required for unemancipated minors.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Saint Mary's Hospital Notice of Privacy Practices. The Notice describes how my health may be used or disclosed. I understand that I should read it carefully.

DATE _____ PRINT NAME _____ SIGNATURE _____

As the representative of the above patient, I acknowledge receipt of the Notice on his or her behalf.

DATE _____ PRINT NAME _____ SIGNATURE _____

**FOR HOSPITAL USE ONLY*** ☐Patient and family unable to sign ☐Patient refused to sign ☐Emergent Care Required

(Document comments) _____

_____ Signature / Date: _____

Saint Mary's HOSPITAL

56 Franklin Street, Waterbury, CT 06706

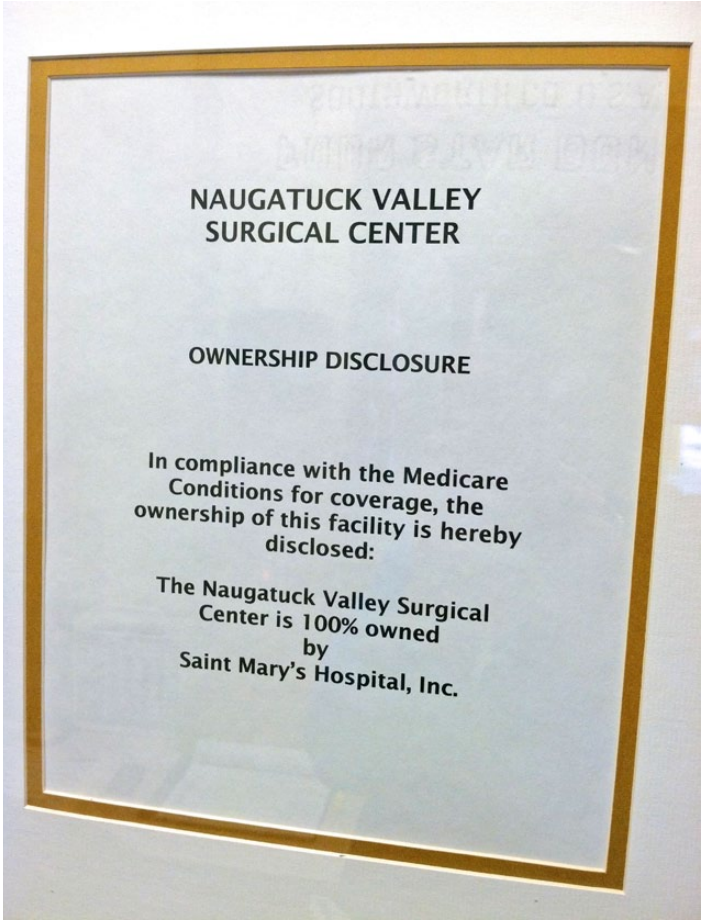
**AUTHORIZATION FOR TREATMENT**

*Place Patient Label Above This Line*

5313L

5313L R 11/14/12

NV/ NAUGATUCK VALLEY
SC/ SURGICAL CENTER
Saint Mary's Hospital


NAUGATUCK VALLEY
SURGICAL CENTER
OWNERSHIP DISCLOSURE
In compliance with the Medicare Conditions for coverage, the ownership of this facility is hereby disclosed:
The Naugatuck Valley Surgical Center is 100% owned by Saint Mary's Hospital, Inc.

NV/ SC/
NAUGATUCK VALLEY SURGICAL CENTER
Saint Mary's Hospital
ENTRANCE
HOURS OF OPERATION
Mon.-Fri. 6:30 a.m. to 5:00 p.m.
Closed Saturday and Sunday
In the event of an AFTER HOUR EMERGENCY
Go to the nearest Hospital
Or call 911 for help

## OUTPATIENT SAME DAY DISCHARGE ORDER INSTRUCTIONS FOR CARE AT HOME

**Activity**

- Everyone reacts differently to anesthesia - You may experience dizziness or sleepiness afterwards. A **RESPONSIBLE ADULT** must be with you for **24 Hours** after surgery.
- Rest at home for 24 hours after general anesthesia or local anesthesia with sedation.
- **Do Not Drive** or operate machinery for 24 hours or as instructed by your physician.
- ☐ You may shower after _____ hours, or ☐ sponge bathe only.

**Medications**

- Take your prescriptions as ordered. If antibiotics are prescribed, finish the entire prescription. If you experience anything unusual such as a rash, nausea, or vomiting, notify your physician immediately. If your pain medication is not effective, notify your physician.
- Avoid driving, operating machinery or drinking alcohol when using pain medication.
- If you take daily Aspirin or blood thinners, resume per your physicians instructions.

**Diet**

- Avoid alcohol for 24 hours after anesthesia.
- Eat light foods that are very easy to digest and progress to a regular diet as tolerated, unless otherwise specified by your physician.

**Wound Care**

- Keep your dressing clean and dry. Do not remove dressing unless instructed to do so.
- Apply ice to _____ for _____ .
- Elevate _____ as instructed.
- Notify your physician regarding excessive bleeding, swelling or pain, fever greater than 101°, any unusual color changes or temperature changes to the operative extremity or if your dressing feels too tight. After surgical dressings are removed any redness, swelling or foul drainage from incision should be reported.

**Special Instructions:** _____

_____

_____

***IF ANY PROBLEMS OCCUR, CONTACT YOUR SURGEON. A NURSE WILL CALL THE NEXT BUSINESS DAY.***
***IF YOU HAD YOUR SURGERY AT THE SURGICAL CENTER, YOU CAN CALL THEM BEFORE 4:30.***
***KEEP THESE INSTRUCTIONS BY THE PHONE SO YOU CAN REFER TO THEM.***

***IN THE EVENT OF AN EMERGENCY PLEASE CALL 911 OR GO TO THE EMERGENCY ROOM.***

***Thank You for choosing Saint Mary's Hospital.***

Surgeon Telephone # _____ Follow up appointment _____

☐ Discharge patient when discharge criteria met.

| | | | | | |
|---|---|---|---|---|---|
| TO/VO BY _____ M.D. | | | I have participated in the development and understand the Discharge Plan. SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: | TIME | AM PM |
| TAKEN BY _____ R.N. | | | | DATE | / / |
| SIGNATURE AND DATE | HOUSE STAFF SIGNATURE | TIME AM PM | NURSING SIGNATURE | TIME | AM PM |
| | | DATE / / | | DATE | / / |
| | | | ATTENDING SIGNATURE _____ M.D. | TIME | AM PM |
| | | | | DATE | / / |

Saint Mary's HOSPITAL
56 Franklin Street, Waterbury, CT 06706

NVSC NAUGATUCK VALLEY SURGICAL CENTER
160 Robbins Street
Waterbury, CT 06708

**OUTPATIENT SAME DAY DISCHARGE ORDER INSTRUCTIONS FOR CARE AT HOME**

**MUST BE COMPLETED PRIOR TO DISCHARGE**

*Place Patient Label Above This Line*

7493

WHITE - MEDICAL RECORDS YELLOW - PATIENT

7493 R 4/23/12

NVSC NAUGATUCK VALLEY SURGICAL CENTER

Saint Mary's HOSPITAL

No. 5928

160 Robbins Street • Waterbury, CT 06708 • (203) 755-6663

Name _____ Age _____

Address _____ Date _____

℞

☐ 1 -24 ☐ 25 - 49 ☐ 50 - 74 ☐ 75 - 100 ☐ 101 - 150 ☐ 150+

_____, M.D.

Refill amounts_____ D.E.A. # _____

Welcome to Naugatuck Valley Surgical Center

H Infonet Google Saint Mary's...aterbury, CT Yahoo! Mail:...ased email! Login | Robert Falcetti iStock Photo:...age | iStock M

NAUGATUCK VALLEY SURGICAL CENTER

Saint Mary's HOSPITAL

Home - Photo Gallery - Directions - Contact Us - Forms - Privacy Policy - AdvanceDirective

About Us | Services | Surgery | Gastro & Pain Management | Kids | Staff | Financial Considerations

## Welcome to Naugatuck Valley Surgical Center

Welcome to Naugatuck Valley Surgical Center, a patient oriented, state-of-the-art outpatient ambulatory surgery center department of Saint Mary's Hospital. We take great pride in providing the highest quality of healthcare to our patients. Our skilled and experienced team "treats your family like our family".

Please take your time to browse our website, and learn more about the services that we can provide to you and your family.

Thank you for visiting the Naugatuck Valley Surgical Center Website.

Designed By MN PCS

Accredited by
Accreditation Association for Ambulatory Health Care, Inc.

Naugatuck Valley Surgical Center
Saint Mary's Hospital
160 Robbins Street, Waterbury, CT 06708
(203) 755-6663

## CARDIOVASCULAR DIAGNOSTIC CENTER BILLING FORM

***Thank you*** for choosing Saint Mary's Cardiovascular Diagnostic Center.

**Here is some important information about how we bill for tests that are performed at the Cardiovascular Diagnostic Center.**

**I understand that I and/or my insurance provider will receive two bills.**

- **One bill is for the professional services of the physician interpreting your test. Saint Mary's Hospital has partnered with Franklin Medical group to provide these professional services. If I have any question regarding the FMG bill, I can call 1-800-925-7270.**

- **The other bill is for the technical services, equipment and supplies provided by Saint Mary's Hospital personnel performing the test. The Cardiovascular Diagnostic Center is an outpatient department of Saint Mary's Hospital. If I have any questions regarding the Saint Mary's Hospital. If I have any questions regarding the Saint Mary's Hospital's bill, I can call 203-709-6428.**

Date: _____ Signature: _____ Relationship: _____

Date: _____ Witnessed by: _____

❑ PATIENT UNABLE TO SIGN _____
(INDICATE REASON)

Date: _____ Witnessed by: _____

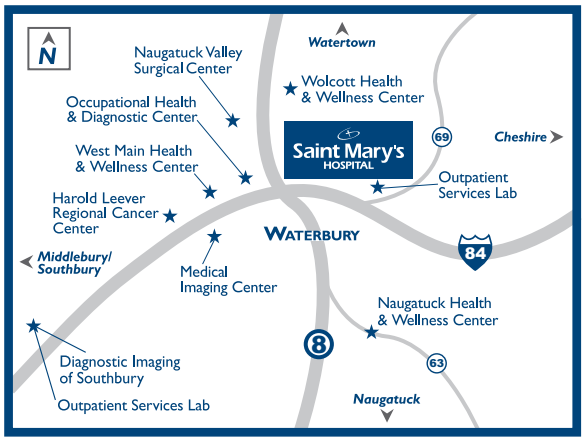
Date: _____ Witnessed by: _____

---

Saint Mary's HOSPITAL
56 Franklin Street, Waterbury, CT 06706

**CARDIOVASCULAR DIAGNOSTIC CENTER BILLING FORM**

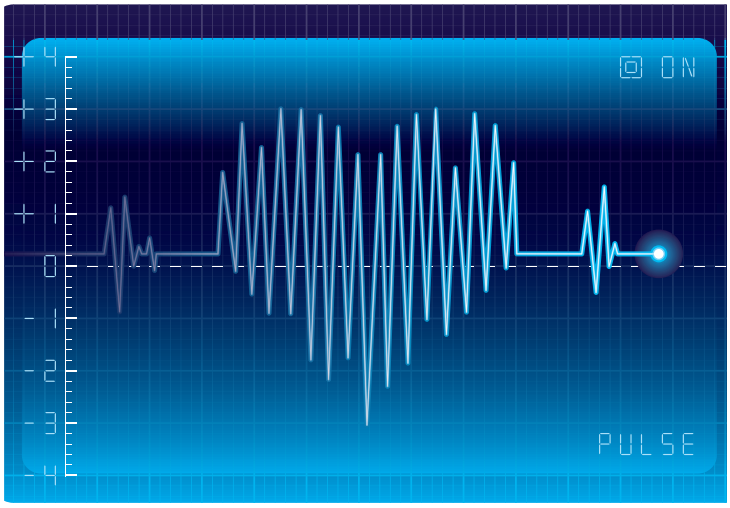
Saint Mary's Health System offers
a range of convenient, quality services
for patients close to home through its network
of health and wellness centers.




Our center is located directly
off I-84 in Waterbury with ample free parking
and easy, first-floor access.
Come visit us at:

1320 West Main Street
Waterbury

For appointments, call (203) 709-4506.




# Saint Mary's Cardiovascular Diagnostic Center

*When it comes to cardiac testing,*
*we don't miss a beat*

Saint Mary's
HEALTH SYSTEM
*Exceptional care. Every patient. Every day.*

*stmh.org*

6679

Saint Mary's
HEALTH SYSTEM
*Exceptional care. Every patient. Every day.*

# Integrated Cardiac Care

## *at Saint Mary's Cardiovascular Diagnostic Center*

The Saint Mary's Hospital Cardiovascular Diagnostic Center features state-of-the-art technology and a caring, experienced staff. As an added advantage for patients, the center is located adjacent to Franklin Medical Group Cardiology, the practice of Dr. Paul Kelly, Dr. Peter Chien, and Mary Kokoska, APRN.

The Cardiovascular Diagnostic Center offers a full range of cardiac testing services. Our highly-skilled and experienced cardiac specialists are dedicated to providing exceptional care for patients who require diagnostic testing.

Our services include:

- Stress testing with nuclear imaging
- Echocardiography
- Vascular ultrasound
- Phlebotomy
- Coumadin clinic
- Arrhythmia monitoring
- Routine maintenance and monitoring of defibrillators and pacemakers

In most cases, test results are shared with referring physicians the same day. For appointments, please call **(203) 709-4506.**

Front

**Saint Mary's**

**Cardiovascular Diagnostic Center**

1320 West Main Street, Waterbury, Connecticut 06708
**PHONE:** 203-709-4506
**FAX:** 203-709-4566
www.stmh.org

*A service of Saint Mary's Health System*

Back

M _____
HAS AN APPOINTMENT ON

☐ MON. ☐ TUES. ☐ WED. ☐ THUR. ☐ FRI. ☐ SAT.

DATE _____ AT _____ A.M. P.M.

IF UNABLE TO KEEP APPOINTMENT KINDLY GIVE 24 HOURS NOTICE

6708

Saint Mary's Hospital, Waterbury, CT – Patient Services

Popular ▾ SMH Infonet Google Saint Mary's...aterbury, CT Yahoo! Mail:...ased email! Login | Robert Falcetti iStock Photo:...age | iStock MapQuest M...ion

Saint Mary's
HEALTH SYSTEM

*Exceptional care. Every patient. Every day.*

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- About Saint Mary's
- Patient Services
- Admission Information
- Physician Services
- Graduate Medical Ed.
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## Patient Services

Behavioral Health Care Services
Cardiac Care
Emergency Medical Services
Community Training Center
EMS Services Provided
Endoscopy Department
Level II Trauma
Lifeline
Medical Imaging Center
Occupational Health
Pulmonary Rehabilitation
Saint Mary's Urgent Care Centers
Sleep Disorders Center
Surgical Weight Control
Women and Children Services
The Birthplace
Children and Family Services
Growing Family Web Nursery
Maternity Pre-Admission Form
Pediatrics
Wound Healing Center

**Saint Mary's Hospital**
**56 Franklin Street**
**Waterbury, CT 06706**
**(203) 709-6000**

## Acknowledgment of Disclosure

Saint Mary's Hospital would like to thank you for patronizing our Urgent Care Facility. We are committed to providing you and your family the best medical care possible. We ask that you read over the following information, initial the boxes and sign your name at the bottom of the page. If you should have any questions, please ask our front desk staff for assistance.

_____ I understand that the Saint Mary's Urgent Care Center is no longer a designated Walk-in Center effective November 18, 2012, and as a result of that change the level of services available has increased.

Urgent Care is the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis without a scheduled appointment. As an Urgent Care Center, we can treat many problems that can be seen in a primary care physician's office, but we offer some services that are generally not available in a primary care physician's office, such as, X-Ray's, treatment of minor fractures, foreign body removal and repair of minor and moderate-severity lacerations.

_____ I understand that the physicians are not employed by Saint Mary's Hospital and that fees charged by these physicians for services provided will be billed separately and apart from the fees charged by the hospital.

_____ I understand that the physician's services will be billed by Long River Physicians.

_____ **Insured Patients:** I understand that the services being provided will be submitted to my insurance carrier as an Urgent Care charge I also understand that some insurance carriers may process this claim as an Emergency Visit and assess an Emergency Room Co-pay/Deductible.

Patient/Guarantor Signature:_____Date:_____

UCC Employee Signature: _____Extension _____

Long River Physician
100 Witmer Road
Suite 220
Horsham, PA 19044
215-442-5046

Saint Mary's Hospital
56 Franklin Street
Waterbury, CT 06706
203-709-6428

Saint Mary's
HOSPITAL
Urgent Care Center

Saint Mary's
HOSPITAL
Urgent Care Center
Lab / Blood Draw Hours
Monday - Friday 7:00am - 6:00pm
Saturday 7:30am - 2:00pm
Sunday 9:00am - 1:30pm
Walk-In / Radiology
Monday - Friday 9:00am-6:30pm°°
Saturday 9:00am - 4:30pm°°
Sunday 9:00am - 1:30pm°°
°°Last Patient Registered
WARNING
STERLING

The care you need
when you need it.
Expert medical care without the Emergency Room wait
Convenient hours and parking
No appointment needed
Most insurances accepted
Saint Mary's
HOSPITAL
Urgent Care Center
ccent Health

# *Thank you*

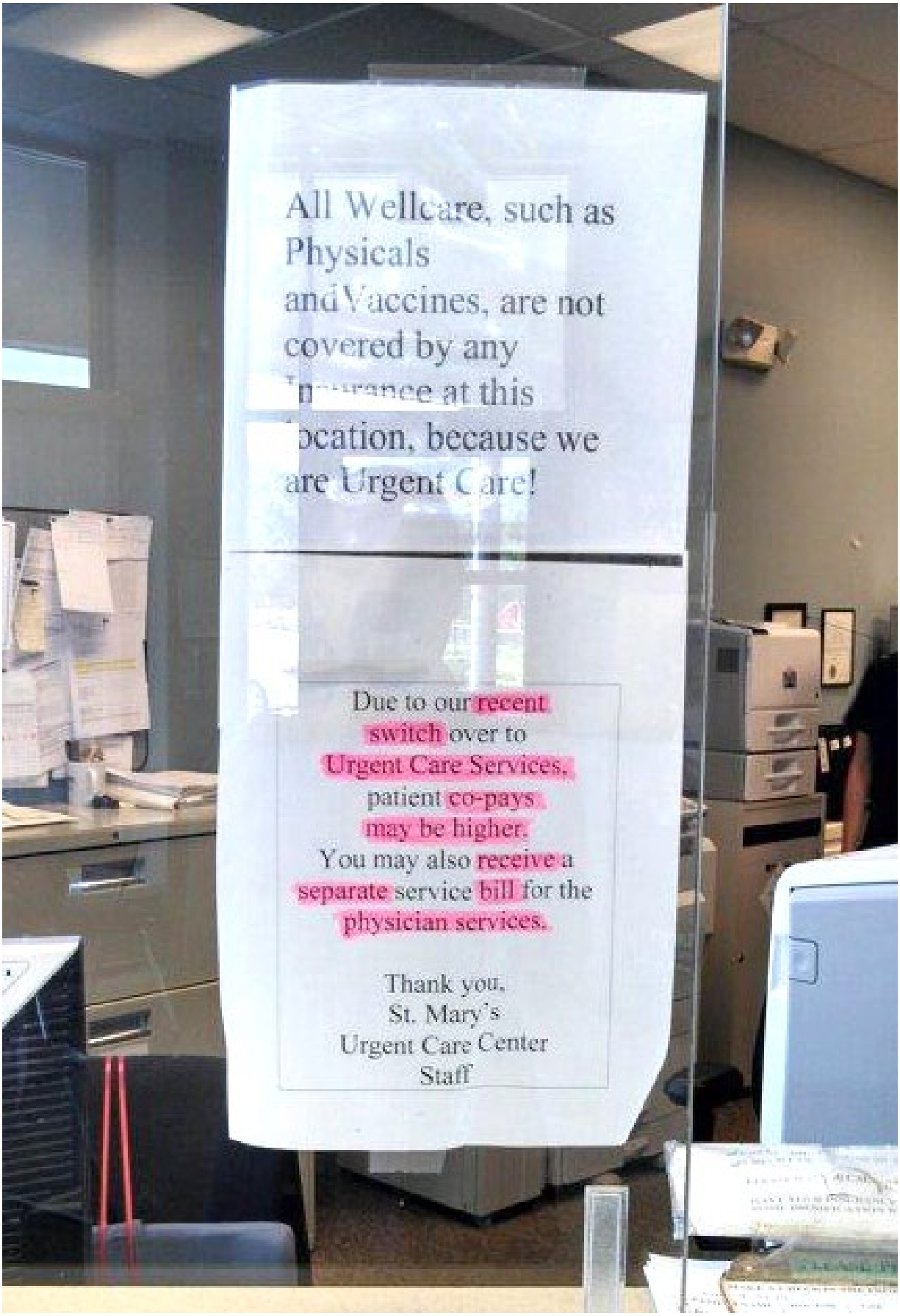
## for choosing Saint Mary's Urgent Care Center

Here is some important information about the billing of your services today.

- **Please be advised that your copay will likely change and you may have two copays.**
- **Please be advised that you will receive two bills:**
  - **One bill is the Urgent Care Center Physician's bill.**
    Saint Mary's has partnered with EmCare, a national company that is providing professional services for Saint Mary's Urgent Care Centers and Emergency Department. The bill you will receive pertains to the physician or physician assistant's professional fees for clinical and diagnostic evaluation, treatment and/or supervision of care. This bill will not include Saint Mary's Hospital charges. This bill will be issued by Long River Physicians. If you have any questions regarding the Urgent Care Center Physician's bill, please call (800) 355-2470.
  - **The other bill is the Hospital bill.**
    This bill pertains to the charges for Saint Mary's nurses, ancillary and technical personnel, equipment, supplies, treatment area, etc. It will not include the Urgent Care Center Physician's fee. This bill will be issued by Saint Mary's Hospital. If you have any questions regarding the Hospital's bill, please call (203) 709-6428.
- **Because of the elevated level of services offered, it is very likely that both your co-pay and the total amount of charges will be higher than the previous walk-in charges.**

Saint Mary's HOSPITAL
Urgent Care Center

EmCare
*Making Health Care Work Better.™*


All Wellcare, such as
Physicals
and Vaccines, are not
covered by any
Insurance at this
location, because we
are Urgent Care!
Due to our recent
switch over to
Urgent Care Services,
patient co-pays
may be higher.
You may also receive a
separate service bill for the
physician services.
Thank you,
St. Mary's
Urgent Care Center
Staff

# EXHIBIT 19

## Saint Francis *Care's* Community Health Outreach Programs

Caring for the community beyond the hospital walls has long been a priority for Saint Francis *Care*. By bringing its services into the community through programs which focus on community health, Saint Francis is able to embrace a myriad of creative solutions for improving our community's health.

Saint Francis' commitment to community health is best demonstrated by the establishment of the Curtis D. Robinson Center for Health Equity (begun as an Institute in 2009) **:** a dedicated platform dedicated to eliminating disparities in healthcare and serving as a leader in health equity. Housed within the Urban League of Greater Hartford, this unprecedented Saint Francis Board-endorsed initiative serves as a hub for community engagement, data collection and use in understanding needs of our community, and bridging the resources of Saint Francis with all communities we serve. Here you will find a multi-cultural, multi-lingual team of physicians, nurses and outreach staff harnessing the health system resources into the identified needs of families in our service areas of Connecticut. They include culturally-appropriate health assessments, health education; community-based clinical services such as health screenings and immunizations. A key principle of the Center's activities is to be culturally and community informed. A survey, for example, indicating the health priorities of 700 African American and Latino members of the community helps give focus to health outreach activities.

Saint Francis *Care* also Saint Francis *Care* partnered with like-minded organizations such as the Hartford Hispanic Council, Tuskegee University, local area places of worship and other community organizations to focus on specific health needs of minority populations in its service area and culturally inclusive training for employees. These health equity initiatives demand a strategic approach to health equity informed by the communities we serve, our partners, and our Saint Francis' team committed to measuring impact on improved care. Hence, research, community engagement, education, and bridging health resources to those seeking care are core activities identified with the Curtis D. Robinson Center for Health Equity.

Examples of our recent successes:

- The 4th Annual Town Hall Meeting – 11/18/14 "Is Our Food Making Us Sick?" sponsored by the Curtis D. Robinson Center For Health Equity provided information to the community in the areas of food policy, nutrition, obesity, reduction and health and community organizing around health issues. The Center nurtures ongoing leadership to bring simple

solutions to complex issues that honor the many contributions needed to assure equitable health for our region.

- Saint Francis Hospital and Medical Center Breast Feeding Heritage and Pride - Saint Francis Hospital and Medical Center in partnership with the Hispanic Health Council has just received a three year grant to expand a program that trains low income African American and Hispanic mothers who are patients of the Saint Francis Center for Women's Health. Through this program women are encouraged to breast feed their newborns using trained peer counselors. The goals of this program are to reduce the risk of Sudden Infant Death syndrome, asthma, allergies, respiratory infections and other problems among newborns in this population of women. Breast feeding also provides vital nutrients for growth and development, encourages development of mouth and jaw and reinforces the mother/baby emotional bonding.
- Maternal Infant Outreach Program (MIOP) – The goals of the City of Hartford MIOP program are to monitor health conditions of high-risk pregnant women in Hartford, to assess preventable risk factors associated with low birth weight, and to help identify effective and ineffective elements of existing efforts. Saint Francis Hospital and Medical Center has participated in this program for many years. Services provided by Saint Francis include pregnancy tests, prenatal care, patient education and nutritional counseling, routine gynecologic care, breast exams, cervical cancer prevention, post-menopausal counseling and hormone therapy along with STD and HIV testing and counseling. MIOP is a system of care that is proven and has demonstrated its effectiveness through reduced infant mortality rates, lower number of babies born with low birth weights, increased number of women accessing prenatal care, higher number of women having full term babies, and more linkages and services to families.

In addition to these targeted programs seeking to address service inequities for minority populations in its service area Saint Francis Care offers a wide range of community education programs to its entire service area population. Those programs are listed below:

Caregiver Support Services

• CREC Magnet School Partnership
•Golfers in Motion Program
• Health Equity Fellowship
• Housing Support
• Joan C. Dauber Food Bank
• Keep-the-Power-On Utility Clinic programs that address underlying social problems, such as poverty, homelessness, and environmental issues.

These activities support community assets by offering the expertise and resources of the healthcare organization.

• Literacy Support Programs
• Medical Legal Partnership Program
• Nurturing Families Network Case Management Services
• Pastoral Counseling Program
• Procurement of Pharmaceuticals for Indigent Clients
• Services for Children and Families Impacted by Child Abuse
• Support for Malta Van Services Healthcare Support Services
• Support of Neighborhood Associations
• The Auxiliary Repetitions Thrift Store

*Community Health Education*
• Bereavement and Spirituality Classes
• Break Free from Smoking Program
• Breastfeeding Support
• Cancer Support Groups
• Cardiac Rehab and Wellness
• Care Management Support Services
• Center for Diabetes & Metabolic Care Program Education and Outreach
• Child Abuse Prevention Education and Outreach
• Childbirth Education Classes
• Colorectal Screening Program
• Community Lectures on Health Promotion, Early Detection, and Disease Management Topics
• CPR and Safety Programs
• Diabetes Support Services
• Domestic Violence Prevention Training
• Golfers in Motion
• Healthy Start and Parenting Programs
• Integrative Health Services Classes
• Lead Poisoning Prevention Education and Outreach
• Mental Health Alliance and Support
• Multidisciplinary Case Management Team for Child Abuse
• Nutrition and Weight Management Programs
• Powerful Tools for Caregivers Program
• Preventive Health Screenings:
- Bone Density Screenings
- Cardiovascular Risk Assessment
- Child Seat Safety
- Diabetes Screening
- Mammograms
- Prostate Cancer
- Skin Cancer Screenings
• Support Groups including

- Amputee Information Series
- Stroke Support Group
- Aphasia Support Group
- Spinal Cord Injury Support Group
- Living with Multiple Sclerosis
- Living with Congestive Heart Failure
- High-risk Pregnancy
- Pregnancy and Infant Loss

• Violence and Injury Prevention Program
• Women's Heart Program Outreach Community-Based Clinical Services

*Other Health Improvement Services*

• Access to Recovery for Substance Abuse Clients
• Adaptive Rowing Program
• Breast and Cervical Cancer Education and Outreach

# EXHIBIT 20

| SAINT FRANCIS Care<br>Policy | Title:<br>**Financial Assistance Policy** | | |
|---|---|---|---|
| ☒ Saint Francis Hospital and Medical Center<br>☒ Mount Sinai Rehabilitation Hospital<br>☐ Saint Francis Medical Group, Inc.<br>☐ Saint Francis *Care* Medical Group, P.C.<br>☐ Asylum Hill Family Medicine Center, Inc.<br>☐ Saint Francis Behavioral Health Group, P.C. | **Proponent Department**<br>Patient Accounting | **Number**<br>ADM 060 | **Level**<br>☒ **System**<br>☐ **Division**<br>☐ **Department** |
| | **Category**<br>☒ **Administrative**<br>☐ **Clinical**<br>☐ **HR**<br>☐ **EOC** | **Published Date**<br>11/2/2015 | **Review Cycle**<br>☒ 1 year<br>☐ 3 years |

## PURPOSE:

It is the policy of Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital (the "Hospital") to ensure a socially just practice for billing patients receiving care at any of its facilities. Financial Relief is a financial assistance program offered by the Hospital for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

## SCOPE:

This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. Excluded from this policy are cosmetic procedures, bariatric services and secured liens on liability cases.

### Application for Financial Relief

1. Application may be obtained from the appropriate hospital personnel: Financial Counselors, Collection Representatives, and Telephone Representatives.

2. The completed and signed application must be returned to the Business Office with the following requested documentation, in the return envelope provided:
   a. Family size - as reflected on prior year tax return; and
   b. Income verification – to include one of the following:
      i. Four most current pay stubs;
      ii. A letter from employer or government agency which verifies income and previous year's tax return; or
      iii. Active Medicaid eligibility screen print that indicates current full Medicaid coverage

   If any of the above required documents are not received, the application will be pending for thirty (30) days. A written notification will be sent to the applicant detailing the missing documentation. If the missing documentation is not provided within twenty (20) days, the application will be denied. An approved application will cover all previous covered services and as well as future qualifying services for the next six (6) months.

3. An application for State Medical Assistance (Medicaid) must be completed for those patients with a verified income below 100% of the poverty guidelines. If the patient is ineligible for Medicaid they will be offered hospital financial relief based on the Medicare allowed amounts.

- If a patient is approved for Medicaid with no spenddown, the proof of eligibility determination from the Department of Social Services can be used as verification of their income and be eligible for 100% financial assistance .
- If the balance on an account is the result of a spenddown, the income guidelines will apply to determine eligibility. The Medicare allowed calculation will apply so the balance may not be eligible for financial assistance.

Effective 1/1/2014: Un-insured applicants must complete an application through Access Health during open enrollment for eligibility determination for a qualified health plan, or HUSKY Health..

4. Eligibility is determined on family size and current income.

   a. Income eligibility is based on the federal poverty guidelines. Patients with income levels **under 200%** of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief.

   b. Patients with income levels ranging between **200% to 250%** of the federal poverty guidelines and who are ineligible for State Medical Assistance will be eligible for financial assistance based upon Medicare allowed amount. This may or may not provide a discount on the patient balance that is owed.

   Self Pay Patients with income over 250% of the federal poverty guidelines will not be eligible for financial assistance but may still receive a self pay discount if applicable.

   Examples:

   - If an insurance payment (cash from insurance) is the same or greater than the Medicare allowed amount for the same service, there will be no patient responsibility. The patient balance will be adjusted 100% with the financial assistance code 97000039.

   - If the insurance payment is less than the Medicare allowed amount, the patient is responsible to pay up to the Medicare allowed amount. Any amount over the Medicare allowed amount will be adjusted with the financial assistance code 97000039 or 5017.

   - Patients with health insurance who have medically necessary inpatient and outpatient services will be eligible to apply for financial assistance in the following instances:

     - Reached their maximum benefits

     - Entire procedure is non covered due to limitations of their policy or diagnosis

     Patients within the 200-250% of the federal poverty guidelines will be required to pay the Medicare allowed amount.

     Patients over 250% of the federal poverty guidelines will be granted the self pay discount.

5. The Self Pay Manager and appropriate personnel must determine eligibility within thirty (30) days of receipt of a completed application.

6. Assessment for other free bed funding is completed as part of the financial assessment.

**PRESUMPTIVE SUPPORT:**

The Hospital recognizes that not all patients are able to provide complete financial information. Therefore, approval for Financial Support may be determined based on limited available information. When such approval is granted, it is classified as "Presumptive Support." No application is required for this group.

Examples of presumptive cases include:

- Deceased patients with no known estate;
- Homeless patients;
- Patient bankruptcies;
- Members of religious organizations who have taken a vow of poverty and have no resources individually or through religious order and
- Patients who are qualified for other State Assistance Programs that are income based.

ADJUSTMENTS GREATER THAN $5,000.00 ARE SUBJECT TO APPROVALS AS FOLLOWS:

<$4,999 - Customer Service Rep/Financial Counselors/Team Leads
$5,000-$24,999 - Supervisor
$25,000-$49,999 - Manager
$50,000-$99,999 - Director of Patient Financial Services
>$100,000 - VP, Revenue Cycle
After obtaining approval, staff will apply adjustment.

To be Noted

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit and Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.
- Cosmetic and Bariatric Procedures are excluded from financial assistance
- Liability Cases that have secured liens are excluded from financial assistance
- Undocumented patients who are eligible for Medicaid Emergency Medical coverage (for their inpatient emergency account) are automatically eligible for financial assistance when proof of eligibility is determined from the Department of Social Services.
- Applications are approved for six (6) months.
- Patients with non-contracted insurance carriers or medically necessary non-covered services may be eligible for a discount up to 45%on a case by case review (no application required).

## CROSS REFERENCES:

Self Pay Billing and AR Management Policy
Emergency Medical Screening and Stabilization/ EMTALA

**APPROVED BY:** Policy requires Vice President approval.

| | |
|---|---|
| Nicole Schulz | Date: |
| Vice President | 11/2/2015 |

## REPLACES:

Financial Assistance Policy 1/30/2015

1

| SAINT FRANCIS Care<br>Policy | **Title:**<br>**SELF PAY BILLING AND AR COLLECTION POLICY** | | |
|---|---|---|---|
| ☒ Saint Francis Hospital and Medical Center<br>☒ Mount Sinai Rehabilitation Hospital<br>☐ Saint Francis Medical Group, Inc.<br>☐ Saint Francis *Care* Medical Group, P.C.<br>☐ Asylum Hill Family Medicine Center, Inc.<br>☐ Saint Francis Behavioral Health Group, P.C. | **Proponent Department**<br>Business Office | **Number**<br>ADM 064 | **Level**<br>☒ **System**<br>☐ **Division**<br>☐ **Department** |
| | **Category**<br>☒ **Administrative**<br>☐ **Clinical**<br>☐ **HR**<br>☐ **EOC** | **Published Date**<br>1/30/2015 | **Review Cycle**<br>☐ 1 year<br>☒ 3 years |

**PURPOSE:** It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following: Patients/patient guarantors shall receive a summarized bill including but not limited to encounter specific information including dates of service, summarized charges, discounts, payments, adjustments and amounts owed.

- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the Access Health CT, State of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial assistance program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given an appropriate amount of time (4 statements or 120 days) to respond to such notices of outstanding financial obligations.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.
- Return mail without other non-identified information is returned, the account may to collections before 120 days.

**SCOPE:**

This policy applies to the Business office and hospital staff

**POLICY:**

**Self-Pay Billing:** Execution of the self-pay billing cycle.

Primary self-pay balances, those balances for which there is no insurance coverage, or self pay balances after insurance has been processed, will receive a series of four statements when the account is released from billing.. Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay.

- First, an account is generated and held for the appropriate min days which allows the charges to be associated with the patient encounter. After the min days are satisfied the account is moved from pre-receivable status to active accounts receivable status in the hospital's receivable system.
- Second, a statement displaying a summary of the total charges and the outstanding balance (after any discounts and recent payments have been applied) is generated and mailed to the patient through a contracted agent.
- Simultaneously a file containing the billed inventory is electronically transferred to a contracted self-pay customer service agent to initiate contact and work with patients for account resolution.

Each statement includes a specific message based upon the status and age of the account. The statement cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. The statement intervals are generated in 30 day intervals and the entire dunning cycle, assuming no interventions, lasts 120 days. All accounts which have an established recurring payment arrangement (payment plan) will receive an alternative self-pay dunning cycle. Payments on payment arrangements must

have consistent payment in accordance with the plan. If installment payments are missed the account is eligible for collection.

**Self-pay A/R Management: Execution of Self-pay Collection Efforts**

Collection efforts on self pay accounts are assigned to a contracted customer service agent from the day the account is ready for billing. The contracted agent receives daily billing files as self-pay claims are generated.

- Follow-up and collection activities will commence upon receipt of the referral.
- Accounts are run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number.
- All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through Access Health CT, the State of Connecticut's Medicaid Assistance program, as well as St. Francis' internal financial assistance program and recurring payment plan guidelines.
- All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. All accounts which have established a recurring payment arrangement in good standing consistent monthly payments for the agreed upon amount are exempt from any bad debt write-off protocols. Should an account become delinquent, a late notice is generated at 15 days a delinquency notice at 30 days past due. If a payment is not received within two months (60 days), a final notice is generated and the account will become eligible for bad debt and written of at the end of the month.

**Self-pay Write-offs: Execution of Bad Debt Write-off Protocols**

- If a mutually agreed upon recurring arrangement is not establish or if the account is not resolved within the 120 day billing cycle, the account automatically becomes eligible for bad debt write-off. Automatic assignment is changed to reflect bad debt assignment of one of two contracted collection agent.
- A system generated write off report is run and sent to management and each collection agent to review.

**Approval of bad debt accounts are as follows:**

$5,000-$24,999 - Supervisor

$25,000-$49,999 - Manager

$50,000-$99,999 - Director of Patient Financial Services

>$100,000 - VP, Revenue Cycle

Upon completion of the report review the account is automatically written off to Bad Debt at the end of the month.

- The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above.
- Any unpaid balance in bad debt with no activity for 180 days, will be returned to the hospital and get referred for secondary placement see **AAB & LEVIN BAD DEBT RETURNS TO EOS CCA PROCEDURE**

## REFERENCES:

**CROSS REFERENCES:** Financial Relief Policy, Emergency Medical Screening and Stabilization/ EMTALA Policy, and AAB & LEVIN Bad Debt returns to EOS CCA procedure.

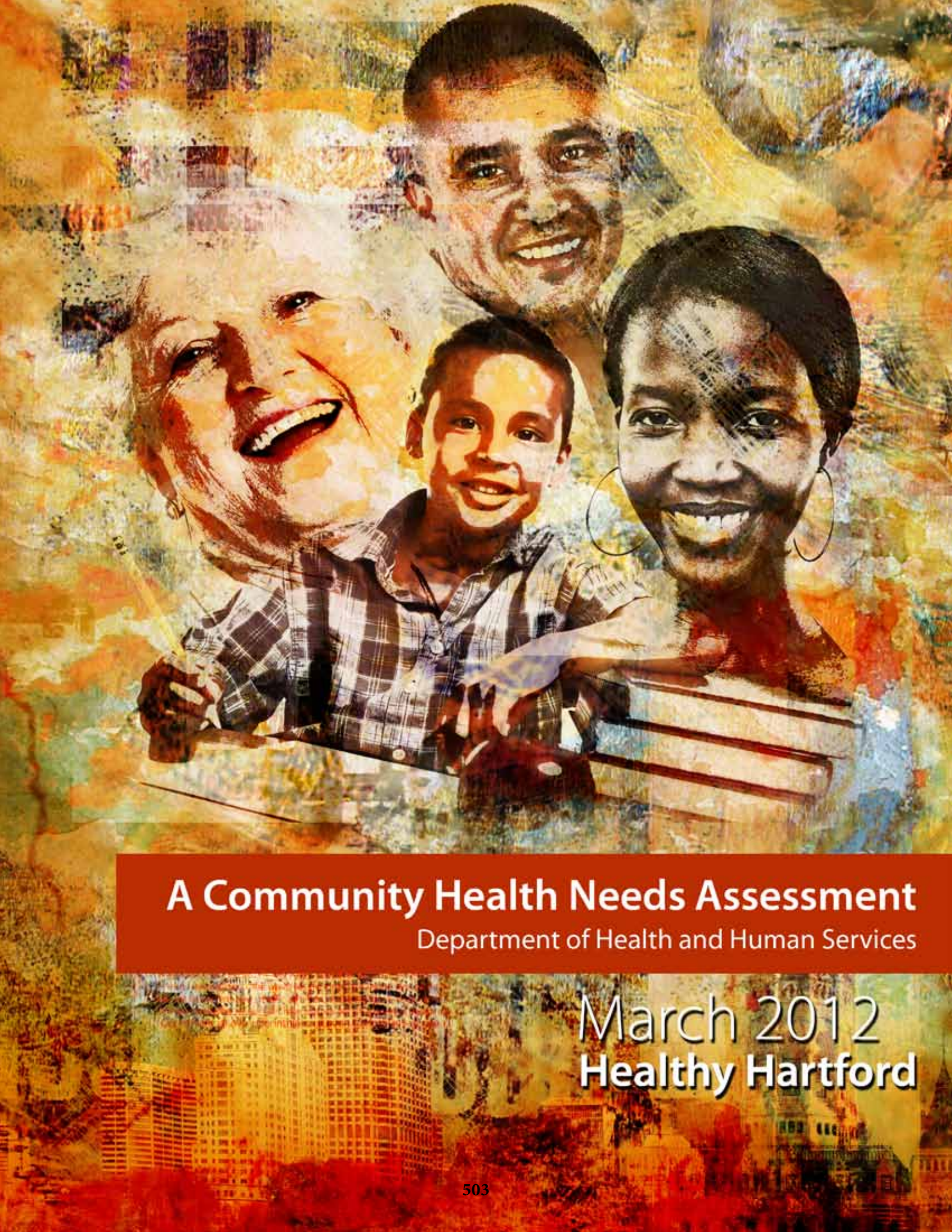
**APPROVED BY:** Policy requires Vice President approval.

| Vice President(s): | Date: | | Date: |
|---|---|---|---|
| Nicole Schulz<br>Vice President<br>Revenue Cycle | 1/30/2015 | | |

**REPLACES:**

Revised Date: 10/1/03; 3/15/04; 9/1/04; 11/01/04; 03/07/05; 10/1/05; 10/01/06; 3/01/07; 4/11/08; 2/21/11; 07/29/2011; 5/22/2013, 2/6/2014;

# EXHIBIT 21



# A Community Health Needs Assessment

Department of Health and Human Services

March 2012

**Healthy Hartford**

**The mission of the Hartford Department of Health and Human Services is:**

To protect the well-being of the people in Hartford, to promote an environment conducive to healthy lifestyles, and to prevent adverse health outcomes. Whenever possible, the Department will endeavor to employ strategies, policies and interventions through community partnerships to reduce health disparities.

# A Community Health Needs Assesment

Hartford Department of Health and Human Services

This report is funded in part by:

# Acknowledgements

**Community Health Needs Assessment Consortium**
City of Hartford Department of Health and Human Services
Connecticut Children Medical Center
Hartford Hospital
Saint Francis Hospital and Medical Center
University of Connecticut Health Center

Under the direction of the Community Health Needs Assessment Consortium, the Community Health Needs Assessment Workgroup began planning this assessment in early 2010. Much thought was put into creating a process and document that would be both useful and enlightening to healthcare organizations, community-based health and social services organizations, and the community at large. The City of Hartford Department of Health and Human Services wishes to thank our community health needs assessment partners for their generous support to this project and to their designated representatives on the Community Health Needs Assessment Workgroup for their professional contributions and collaborative efforts throughout the study process. Special thanks go to the Urban Alliance for providing data, analysis, and review of the Hartford Survey Project: Understanding Needs and Service Opportunities.

We would also like to thank Holleran Consulting LLC for their expertise in community health assessments and for preparing the community profile. This document has been produced for the benefit of the community. The City of Hartford Department of Health and Human Services and its community health needs assessment partners encourage use of this report for planning purposes and are interested in learning of its utilization. We would appreciate your comments and questions, which may be directed to the City of Hartford Department of Health and Human Services by phone at (860) 757-4700.

The report, as well as the raw data used to generate our findings is available for download at: http://hhs.hartford.gov.

City of Hartford
Department of Health & Human Services
131 Coventry Street
Hartford, CT 06112

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## The goals of this CHNA are:

- To provide a baseline measure of key health indicators
- To inform health policy and health strategies
- To provide a platform for collaboration among community groups including schools, businesses, policy makers, and others to impact current health status
- To act as a resource for individuals, agencies, and institutions looking to identify community health needs and priorities
- To establish benchmarks and monitor trends in health status of Hartford residents
- To assist with community benefit requirements as outlined in the PPACA

The information included in the CHNA provides the foundation upon which community health programs and interventions can be targeted, developed, and evaluated with the ultimate goal of improving the health of the community and its members.

# II. Summary of Key Findings

**Social Determinants** – Many socioeconomic and cultural characteristics of the population living in Hartford drive the main health concerns. The findings in the secondary data profile point to higher concentrations of people that are at increased risk for unhealthy living merely because of their race, age, income, educational status, or family status. The Key Informant interviews, the Hartford Survey Project, and data from the Health Equity Index validate the concern for marginalized and underserved populations.

- The top 5 quality of life issues mentioned by Key Informants as currently having the most negative impact in Hartford were **poverty**, **job opportunities**, **quality of housing**, **neighborhood safety**, and **education**.

- Hartford has a greater number of renters than owners, more households with mothers being the sole head of household, and lower residential property values than the state, overall. These are associated with poor health outcomes. There is also a higher rate of service occupations when compared to the state and nearly 1/5 of the city's labor force unemployed. With subpar housing and employment levels, overall economic security rates low.

- Nearly a third of Hartford's adults do not have a high school diploma, and the average graduation rate is 77%; high educational attainment is one of the key determinants of community health since it leads to increased economic security and occupational prestige.

- More than 10% of all of the crimes committed in Connecticut in 2009 were committed in Hartford, even though Hartford accounts for less than 4% of Connecticut's population, and there are certain types of crimes that occur with greater frequency in Hartford than in the state overall.

- Compared to other Connecticut cities, the overall environmental quality in Hartford is poor; HEI scoring for waste stream and water discharge pollutants were low. The underlying perception of the city as "unclean" could also impact individual health decisions.

- Less than half of Hartford's residents are registered to vote; a trend that is often associated with fewer community resources and support networks.

## Health Indicators

*Cancer* incidence for all types (specifically lung and prostate) is well below the national and state levels; however, it is important to keep in mind that Hartford has a relatively young population when compared to state and national figures. Key Informants also perceived cancer as less of a priority with only 11.9% respondents ranking it within their top five health issues.

- In general, chronic lower respiratory disease death is lower in Hartford than across the nation or in the state; however, asthma hospitalization rates in Hartford are much higher when compared to the state, with children and adult rates that are at least three times higher than the state rate. Asthma, not one of the options provided in the Key Informant survey, was the most frequently written-in health issue by participants.

- Although one of the top health issues identified by Key Informants was violence, most respondents perceive that violent acts, while isolated in Hartford, are a product of a depressed economic situation. Hartford accounts for more than a third of all murders in the state, and experiences a higher percentage of assaults. This disproportionate and avoidable indicator negatively impacts the overall quality of life in the city.

- There is a much younger population in Hartford compared to the state and nation that is reflected in the mortality rate. This is also reflected in a lower occurrence of the top ten national causes of death, which are often age-related. However, the much higher age-adjusted rate suggests that the elderly population, albeit small, is dying at a very high rate. Infant and neonatal death rates are much higher in Hartford than the state and nation. Hartford also has considerably higher rates of infectious/communicable diseases than the state.

- There is an indication that obesity is a concern for Hartford. Health indicators for heart disease are worse for Blacks and Hispanics, and those who live below the poverty threshold; diabetes rates in Hartford have been increasing in recent years.

**Access to Care** – Access to care was commonly cited in both the Key Informant study and the Hartford Survey Project. While the Hartford Survey Project concluded that the top four barriers to care were lack of knowledge about existing services, lack of available services, inability to pay, and lack of transportation, the Key Informant study showed a need for improving access to care across the board for a variety of underserved populations.

# III. Methods: How We Obtained the Data

The data in this report were compiled from a variety of resources, and includes both quantitative and qualitative data. Additionally, it includes very specific information on critical health indicators and broader information regarding the social determinants of health.

The CHNA report synthesizes findings and data from the following three sources:

**Key Informant Interviews** – Each Workgroup member identified 5 to 10 people in management or leadership positions with various community organizations including health and human services, religious organizations, and government agencies; 85 unique Key Informants were identified by the Workgroup. Respondents were asked to critically evaluate health needs pertinent to the community through their experience. Survey questions focused on underserved populations and access to care issues in Hartford. In total, 59 interviews were conducted; see Appendix for a complete list.

**The Hartford Survey Project** – In order to better understand Hartford's human service needs and barriers to receiving services, a face-to-face survey conducted by the Urban Alliance was completed between October 2010 and January 2011. 402 resident surveys were completed at 12 locations throughout the city to promote geographical and ethnic diversity among respondents; these locations included grocery stores, pharmacies, and community events and programs. Respondents were asked if they would benefit from any of 12 service areas, the possible barriers to obtaining these services, and which three areas of the 12 have a need for additional services. In addition, they were asked to rank the top three service areas in Hartford that they believed were in most need.

Of the total respondents, 57% were female and 43% were male. The ethnicity breakdown was 39% African American, 37% Latino, 9% white, and 8% West Indian. Age categories for respondents were 27% between 18 and 29 years old, 42% between 30 and 49, 24% between 50 and 64, and 6% were 65 and older.

**Secondary Data** – Holleran, in coordination with HHS, prepared the initial community profile for Hartford from secondary data sources. In addition the following sources of data were used throughout this assessment:

- Connecticut Department of Public Health Vital Statistics and Health Outcomes
- Women's Health Quick Health Data Online via the Office on Women's Health (US Department of Health and Human Services)
- Health Data Interactive via the Centers for Disease Control and Prevention
- Connecticut Labor Market Information via the Connecticut Department of Labor

There was also an analysis of local, state, and national 2009 U.S. Census Bureau data collected via the annual American Community Survey; this data is available via the Census Bureau's website.

HHS was also able to use the Connecticut Health Equity Index (HEI) to build upon and enhance the findings from the original information. Developed by the Connecticut Association of Directors of Health (CADH), a non-profit membership organization that represents local directors of health departments and/or districts in the state, the HEI can be used to identify social, economic, and environmental conditions and their correlations or relationships to specific health outcomes. Key social determinants of the HEI include: civic involvement, community safety, economic security, education, employment, environmental quality, and housing. Collectively, these social determinants form the fabric of social and economic opportunity and a healthy environment, as well as provide insight to how social determinants may affect health outcomes and health care services of various populations living in the area of interest. The HEI is an excellent tool for determining how social factors are associated with community health, and by using up-to-date data sources, HEI's commitment to quality improvement evolves along with Connecticut's communities.

Hartford is one of three pilot sites in the state that was selected to test and evaluate the HEI for its use in mobilizing a community, stimulating sustainable action, increasing knowledge of health equity concepts and their application, and prompting structural changes that reflect local needs. Data collection for the HEI began in 2007 and continues through 2012. The HEI is based on a ten-point measurement scale, where 1 is a low score, which represents a less favorable community condition or health outcome, and 10 is a high score, which symbolizes a more favorable community condition or health outcome.

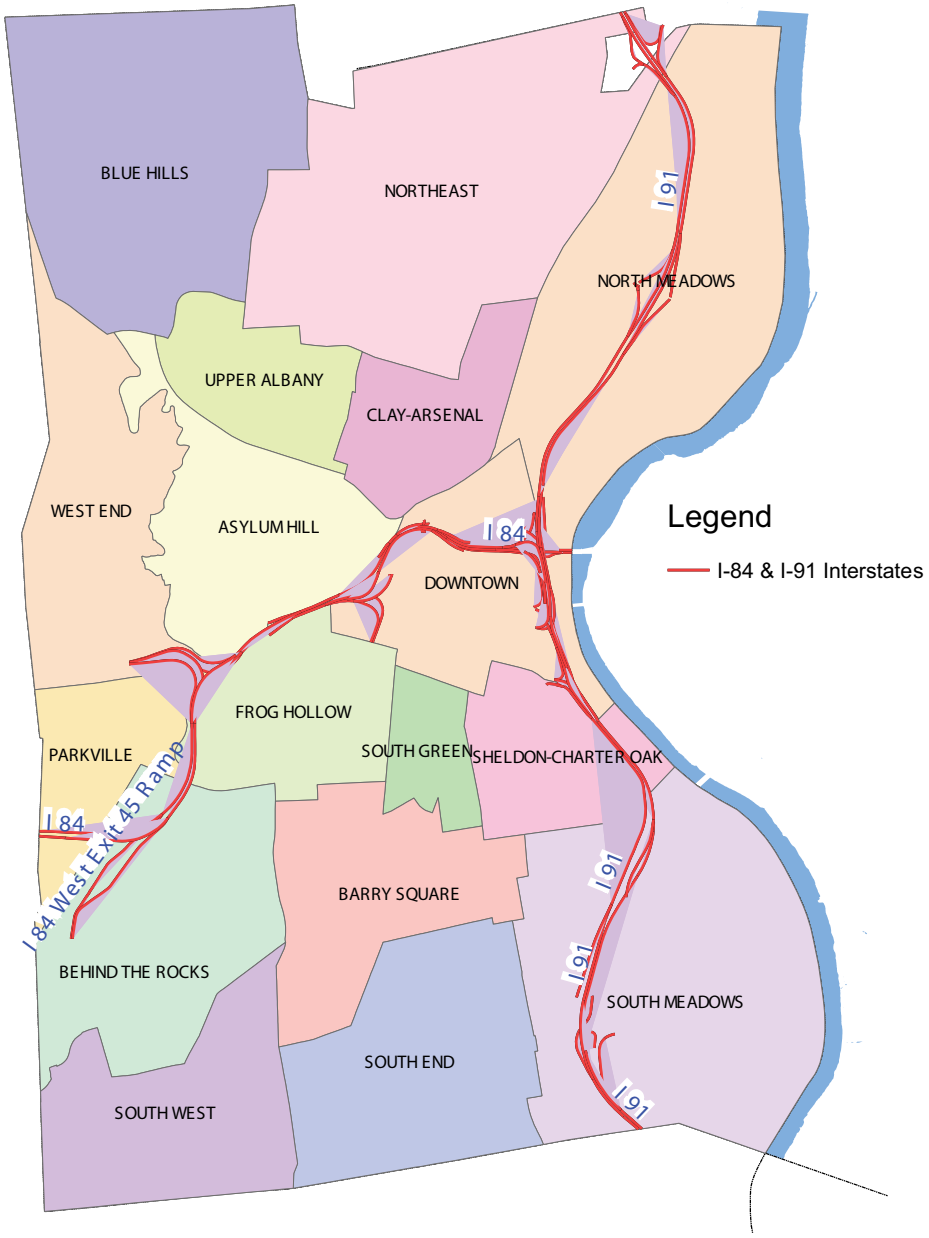
HEI maps were used to compare neighborhoods by social determinant or health outcome indicators. This comparison includes both the North Meadows and South Meadows neighborhoods for analysis, although the former is mainly comprised of car dealerships and landfill, and the latter with a small airport, a water pollution plant, and various commercial and industrial businesses. Together, both neighborhoods are home to less than 3% of Hartford's total population and must be considered when viewing the maps.

A feature of the HEI is that for every social determinant listed (civic involvement, community safety, economic security, education, employment, environmental quality, and housing), the varying factors used to determine the indexing are analyzed with each of the health outcomes in the index (accident/violence, cancer, cardiovascular, childhood illness, diabetes, health care access, infectious disease, life expectancy, liver disease, mental health, prenatal care, renal disease, and respiratory illness). Strength correlations are derived using Spearman's rank correlations, and are generated between the social determinant selected and significant health outcomes. The strength of a correlation is measured between 0 and 1, and the closer the coefficient is to 1 the stronger the correlation between the measures; a correlation of 0

signifies no statistical relationship between measures. Direction of a correlation is measured by signaling a correlation as positive or negative. A positive correlation signals a direct relation between two measures, while a negative correlation signals an inverse relationship. All correlations generated by the HEI are statistically significant.

The maps displayed throughout this report use a color gradient to indicate how Hartford neighborhoods rank with each other with regard to a specific social determinant or health indicator; the darker the color means the lower the rank. The subsequent map is a legend for all Hartford neighborhood names and should be referred to for neighborhood identification.

Map 1. **City of Hartford and Neighborhoods**



# IV. Demographics

Hartford is the capital of the State of Connecticut and the seventh largest city in New England. At almost 400 years old, Hartford is one of the oldest cities in the country and at one point was one of the wealthiest. Still rich with history, it is home to the oldest public art museum and oldest public park in the nation. Starting in the late 1950s, many of the city's residents began moving to the suburbs, possibly accelerated by the construction of two major interstate highways intersecting within the city. And even though the metropolitan area ranked 32 out of 318 nationally in total economic production (second behind San Francisco in per capita economic activity) and the sixth lowest poverty rate of all Metropolitan Statistical Areas (metropolitan statistical area is a geographical region with a relatively high population density at its core and close economic ties throughout the area) for the 2010 census, the city itself remains one of the poorest in the nation; 31.9% of all its residents, and 38.3% of its families with children under 18 years old are living below the poverty line.

The population in Hartford is 124,775, with a **gender** ratio close to state and national ratios of 49% male and 51% female. Hartford is proportionally younger than the state and the U.S., which impacts numerous aspects of health including rates of some types of cancer, violence, and levels of unintended injury.

Table 1. **Age Categories for Hartford, Connecticut and the U.S.**

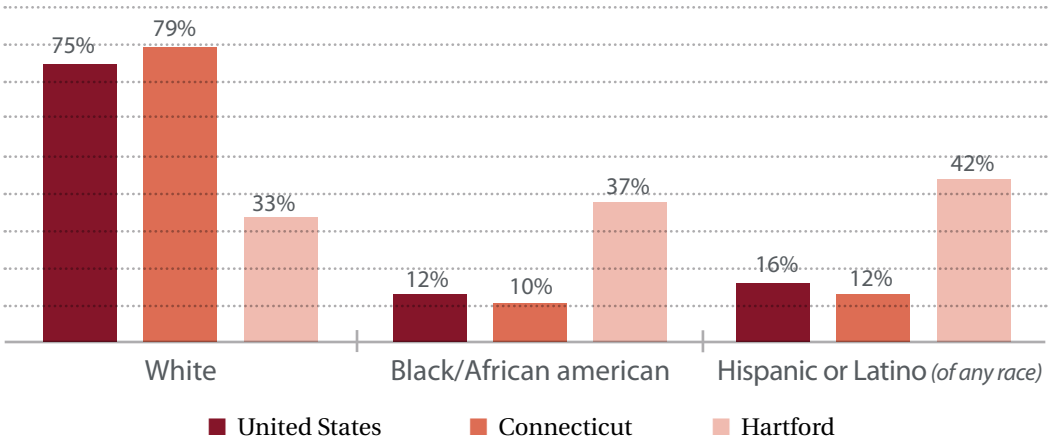
| | HARTFORD | CT | US |
|---|---|---|---|
| 0-19 years | **34%** | 26% | 27% |
| 20-44 years | **37%** | 32% | 34% |
| 45-64 years | **20%** | 28% | 26% |
| 65 and older | **10%** | 14% | 13% |

The **ethnic composition** of Hartford is mostly a mix between Hispanic/Latino of any race, Black/African American, and white. Hartford's white population is at a lower ratio than the U.S. and state while the proportion of Black and Hispanic/Latino residents is significantly higher. Ethnic variation in cultural norms, English comprehension, and beliefs about health impact the mode of health care delivery and how patients respond to health care services. This variation creates a need for increased awareness and sensitivity among service providers.

A significant percentage of Hartford residents can trace their heritage to Puerto Rico and the West Indies; in the 1940s, many immigrants from these areas moved to Connecticut to work in tobacco fields. 78% of Hartford's Hispanic/Latinos self-reported to be Puerto Rican in the 2010 census. Typically, West Indians are grouped with "Black/African American" in census data, which makes it difficult to highlight cultural differences. However, it is important to

note that the ethnic landscape in Hartford is changing as a greater number of families and individuals from Eastern Europe, Africa, and Southeast Asia continue to make Hartford their home.

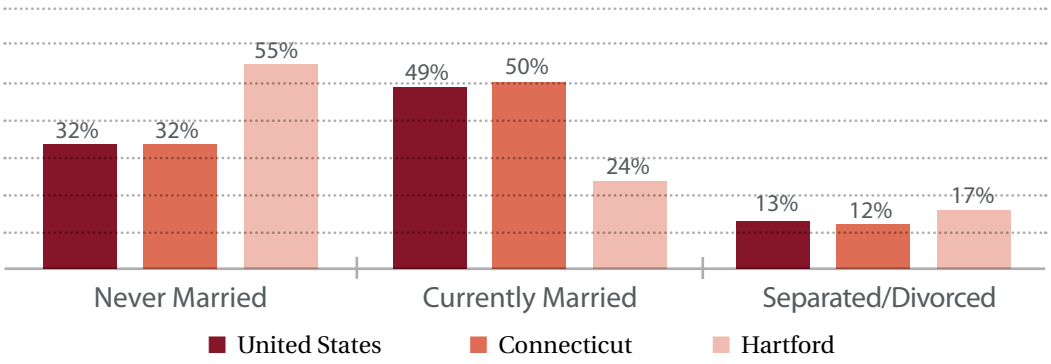
Figure 1. **Ethnic Composition for Hartford, Connecticut, and the U.S. (2009)**




This ethnic breakdown impacts the primary **language spoken** at home. The percentage of Hartford's population who only speak English is 52%, which is lower than a state and the nation comparison. Additionally, approximately 35% of Hartford residents speak a language other than English; the high percentage of non-English speakers could pose a barrier for access to all kinds of health promoting opportunities.

With regard to **marital status**, Hartford's population has a notably larger percentage of people who have never been married when compared to the state and the nation; the City of Hartford also has a smaller comparative percentage of people who are currently married and not separated. The data regarding separated/divorced residents and widowed residents are similar to state and national averages; however, the rate of legally separated couples (de facto separation while remaining legally married) in Hartford (5%) is twice that of the nation (2%).

Figure 2. **Marital Status Statistics for Hartford, Connecticut, and the U.S. (2009)**



# VI. Social Determinants of Health

Quality of life issues are indicators that include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging [2]. During this assessment, Key Informants were asked a variety of questions about quality of life in Hartford. For nearly all quality of life questions, 50% or more of informants ranked them as "Poor" or "Very Poor."

Table 2. **Poorly Rated Quality of Life Measures by Key Informants**

| QUALITY OF LIFE | RATED "POOR" OR "VERY POOR" |
|---|---|
| Poverty | 93.1% |
| Job opportunities | 87.3% |
| Quality of housing (affordable, in good condition) | 72.4% |
| Neighborhood safety | 71.9% |
| Schools/education | 65.5% |
| Clean, litter-free neighborhoods | 63.1% |
| Road/traffic conditions | 53.6% |
| Availability of recreational activities | 52.6% |
| Availability of care for children | 31.6% |
| Water or air pollution | 26.4% |

This information provides insight for those who are regularly involved in the health and human services sector. The following section will addresses social determinants of health, and how Hartford rates relative to state and national figures.

## Housing

Adequate housing provides shelter and comfort to its inhabitants, both of which impact overall well-being. One of the measures used to evaluate the association of housing and health is the number of subsidized housing units per 1000 local residents as defined by the Connecticut Housing Finance Authority. Using 2005 data, the HEI correlated housing strongly with infectious disease in Connecticut, and Hartford received the overall lowest housing score in the HEI when compared to the rest of the state.

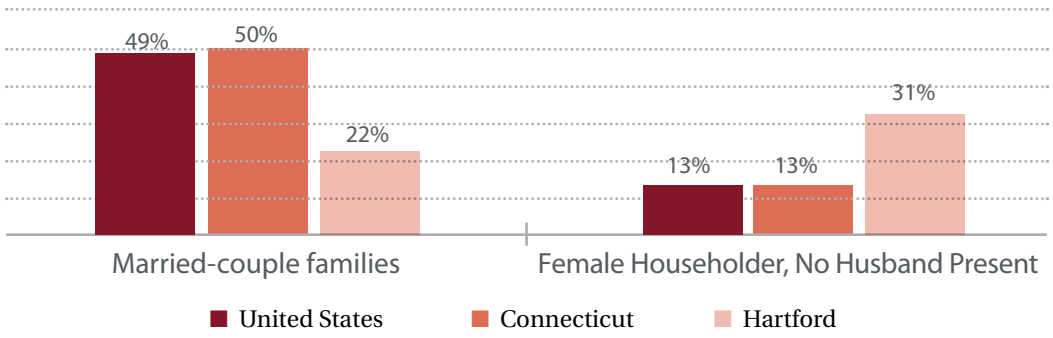
Subsidized housing is abundant in Hartford. As is typical throughout the United States, these subsidized housing units have become a feature of low-income and resource-poor areas. In Hartford, residing in subsidized housing is correlated with numerous health outcomes, such as increased rates of chlamydia and/or gonorrhea, asthma hospitalizations, infectious and parasitic diseases, homicides, drug-induced deaths, mental health hospitalizations, and births not receiving prenatal care in the first trimester.

A cursory analysis of **housing occupancy** in Hartford reveals that the city has over 44,000 occupied housing units of which 26% are owner-occupied; the state average is 69%. A higher rate of rental units is associated with poorer quality of housing and impacts health. Over 70% of Key Informants surveyed ranked housing quality at either "Poor" or "Very Poor." Further highlighting the housing issue, homelessness was the issue recognized as most in need of additional services by those surveyed by the Urban Alliance (45%).

Lower residential property values, accompanied by lower sales prices and a greater number of foreclosures are strongly associated with lower quality neighborhoods. Neighborhoods with these negative housing characteristics typically have higher crime rates, lower quality school systems and a poor physical environment (sidewalks, parks and properties). For 2010, the average assessed residential property value in Hartford was $43,689, which is significantly lower than the state's average value of $209,025; and the average sales price of an existing home was $164,462, which is lower than the state's average home sales price of $288,948.

Hartford **household statistics** for family (59%) and non-family households (42%) are similar to state and national rates, but deviate substantially for the percentage of female householders with no husband present (much higher than state and national) and the percentage of married-couple families (much lower than state and national). Additionally children in Hartford are almost three times as likely (19%) than those in the rest of Connecticut (7%) to live in households with no husband present.

Figure 3. **Household Types for Hartford, Connecticut, and the U.S. (2009)**




In the HEI, Hartford has a housing indexed score of 3, which is a less favorable condition in this category. Some of the calculating factors used to determine this score are rental vacancy rates as a percentage of rental units, owner occupied housing as a percentage of total housing units, and median gross rent as a percent of household income. These measures were calculated using data from the 2000 US Census.

Table 3. **Health Indicators Related to *Housing***

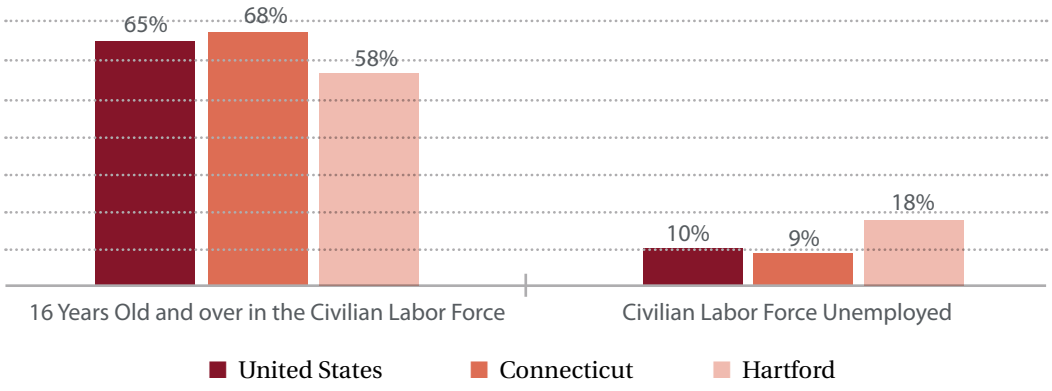
| | HEI INDEX | CORRELATION COEFFICIENT |
|---|---|---|
| Infectious Disease | 2 | 0.55 |
| Health Care Access | 2 | 0.47 |
| Childhood Illness | 1 | 0.42 |
| Accidents/Violence | 3 | 0.40 |
| Mental Health | 2 | 0.37 |
| Renal Disease | 2 | 0.33 |
| Life Expectancy | 3 | 0.31 |
| Cardiovascular | 3 | 0.29 |
| Respiratory Illness | 4 | 0.29 |
| Diabetes | 3 | 0.24 |
| Perinatal Care | 3 | 0.22 |
| Liver Disease | 2 | 0.20 |
| Cancer | 5 | 0.18 |

**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

## Employment

As of September 2011, Hartford's unemployment rate was 15.6% according to the Connecticut Department of Labor's Labor Force Data, which is nearly twice the rate as the United States (8.8%). Against this backdrop, it is fitting that surveyed residents of Hartford rank job training/employment assistance as one of the top three service needs in the community. Key Informants had a similar view with 87% ranking job opportunities in Hartford as "Poor" or "Very Poor."

Figure 4. **Employment in Hartford, Connecticut, and the U.S. (2009)**




The percentage of workers in Hartford in management, professional, and related occupations (21.1%) is smaller than the state and nation (40.3% and 35.7%, respectively). Conversely, the percentage of those in the labor force with service occupations is much higher in Hartford

(34.4%) than across Connecticut and the nation (17.3% and 17.8%, respectively). With this disproportionate representation of Hartford residents across these occupational groups and the strong correlation between employment and health care access, one can see how Hartford struggles to maintain a healthy community profile.

Table 4. **Health Indicators Related to *Employment***

| | HEI INDEX | CORRELATION COEFFICIENT |
|---|---|---|
| Health Care Access | 2 | 0.54 |
| Childhood Illness | 1 | 0.48 |
| Accidents/Violence | 3 | 0.37 |
| Life Expectancy | 3 | 0.35 |
| Respiratory Illness | 4 | 0.28 |
| Infectious Disease | 2 | 0.28 |
| Cardiovascular | 3 | 0.28 |
| Perinatal Care | 3 | 0.26 |
| Mental Health | 2 | 0.23 |
| Cancer | 5 | -0.19 |

**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

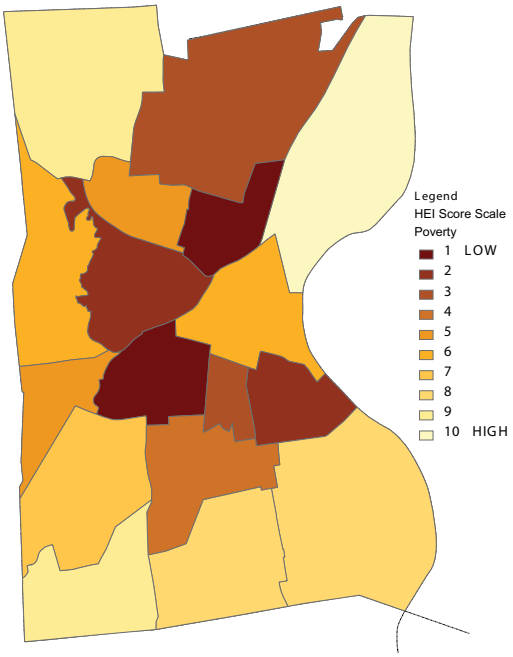
The lack of employment has long been linked to increased rates of mortality. For Connecticut, unemployment has been strongly correlated with decreased health care access, which can serve as a partial explanation for the correlations with a decreased life expectancy, and increased incidences of respiratory illness, and infectious and cardiovascular disease, as well as illness among children. This is reinforced by responses to the Key Informant survey where finances and access to health care were identified as significant barriers.

## Economic Security

Hartford received the lowest possible score on the HEI for the majority of factors that determine economic security. Additionally, 93% of Key Informants rated Hartford's poverty level as either "Poor" or "Very Poor" on the Quality of Life section of the survey. Results from the Urban Alliance survey were similar, with employment opportunities and financial assistance topping the list of services needed. According to a report from the Robert Wood Johnson Foundation, income and educational attainment are the two most commonly used markers of socioeconomic status or position in the United States [3]. Both are strongly related measures of health and health-related behaviors. These factors can influence health through the direct effects of extreme poverty (such as malnutrition or exposure to extreme heat or cold) as well as health effects due to chronic stress; these can include the triggering and exacerbation of depression and cardiovascular disease [4].

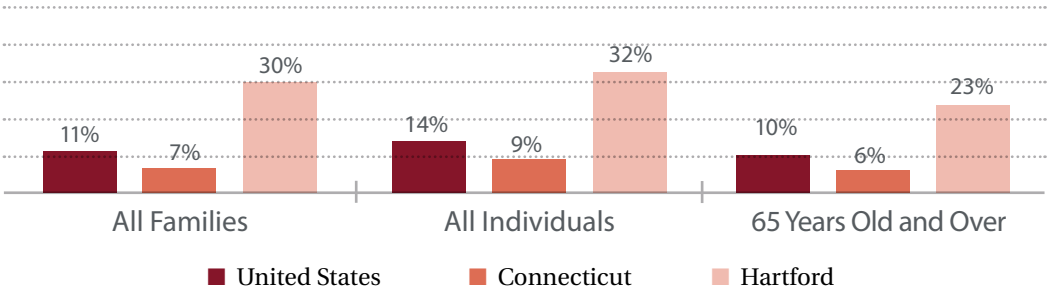
Below is a representation of how Hartford neighborhoods compare to each other with regard to poverty using HEI indexing from the 2000 U.S. Census. Using the color gradient in the legend, the darker colors indicate a lower ranking and higher level of poverty.

Map 2. **HEI Poverty Score by Neighborhood**




With 30.25% of Hartford's families living in poverty, the poverty statistics for the city are three times higher for families than in the United States overall and over 4 times greater than in Connecticut. Similar patterns have been documented for residents and for those over the age of 65.

Figure 5. **Poverty in Hartford, Connecticut, and the U.S. (2009)**




The **income statistics** for Hartford illustrate that the median income per household and family, are significantly less than the state and national figures.

Table 5. **Income Statistics for Hartford versus State and Nation**

| | HARTFORD | CT | US |
|---|---|---|---|
| Median Household | **$28,300** | $67,034 | $55,221 |
| Median Family | **$33,805** | $83,069 | $61,082 |

In Connecticut, living in poverty is correlated with higher rates of chlamydia and gonorrhea, trauma-related hospitalizations and ED visits, mental health ED treatments, homicide, hepatitis C, diabetes, drug and alcohol induced deaths, low and very low birth weight babies, and infectious and parasitic diseases.

## Education

Just as low levels of employment impact community health, so does low educational attainment. 13.9% of Hartford residents perceive education to be one of the top three needs for the community. Key Informant survey respondents noted that the best way to promote wellness and prevention of illnesses in Hartford residents is through education. One respondent noted that starting with school-age children is the best way to achieve these goals. Another declared that it is necessary to tailor the education to "racial, cultural and other different types of understandings to get to the people of the city," and that the frequency of wellness education should be "not just doing it once a year" in order to convey necessary concepts.

Results from the Connecticut Mastery Test and Connecticut Department of Education were used to establish a connection to community health, as indicated in the following table:

Table 6. **Health Indicators Related to *Education***

| | INDEX SCORE | CORRELATION COEFFICIENT |
|---|---|---|
| Childhood Illness | 1 | 0.73 |
| Life Expectancy | 3 | 0.64 |
| Infectious Disease | 2 | 0.59 |
| Health Care Access | 2 | 0.57 |
| Accidents/Violence | 3 | 0.55 |
| Cardiovascular | 3 | 0.51 |
| Mental Health | 2 | 0.42 |
| Respiratory Illness | 4 | 0.41 |
| Renal Disease | 2 | 0.39 |
| Diabetes | 3 | 0.38 |
| Perinatal Care | 3 | 0.34 |
| Liver Disease | 2 | 0.21 |

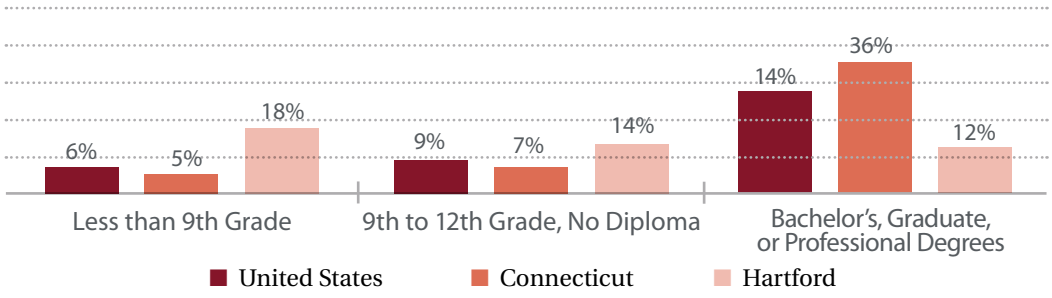
**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

As the demographic data indicates, Hartford residents are less likely to graduate from high school and are less likely to obtain post-secondary education when compared to the state or nation as a whole. The strong correlations suggest that a higher educational attainment leads to better health throughout an individual's lifespan, and better health and education enable people to realize their capabilities to be productive members of society [5], with greater potential for positively impacting the community.

In Hartford, low rates of educational attainment are coupled with lower standardized test scores and less frequent renovations of the city's public school facilities; according to the Connecticut State Department of Education's Connecticut Education Data and Research (CEDaR) website, the average number of years since a major renovation for Hartford's elementary, middle, and high schools is 25.8, 33.8, and 17.5 years, respectively. As indicated in the table above, education is correlated with a host of preventable poor health outcomes including increased rates of childhood illness, respiratory illness, renal and liver disease, diabetes, and infectious diseases; poorer cardiovascular health; and frequency of accidents and violent incidents. Other correlations to education include lower life expectancy, lower rates of perinatal care and health care access, and worse mental health outcomes.

Over 30% of Hartford's adults of 25 years and older do not have a high school diploma, which is significantly higher than the 12% for the state. Conversely, the percentage of Hartford's population with a bachelor's degree or higher is also lower than both state and national figures at 12% when compared to 36% for the state. When these data are examined more closely it becomes clear that the problem of low **educational attainment** begins early for many, with 18% of Hartford residents over age 25 having less than a 9th grade education and another 14% having attained from 9th and 12th grade but without a diploma.

Figure 6. **Educational Attainment of Adults 25 Years and Older for Hartford, Connecticut, and the U.S. (2009)**

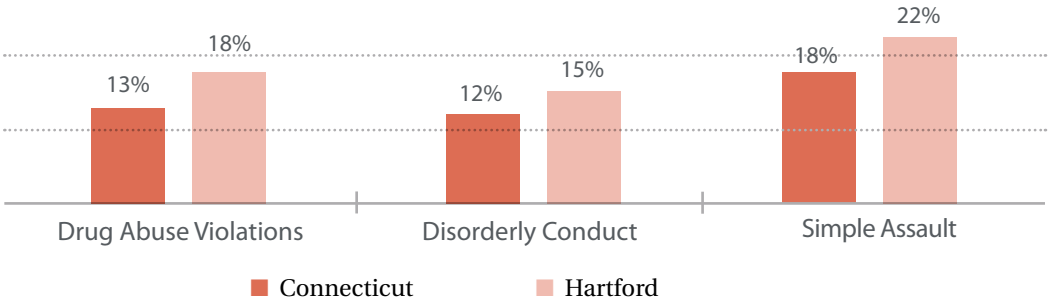



## Community Safety

The HEI measures community safety by the rate of crimes against persons or property published by the 2004/2005 Connecticut Uniform Crime Reports, and within this framework Hartford receives the lowest score of 1 indicating high rates of crime. However, the crime statistics found in the Secondary Data Profile are potentially inconclusive because a high

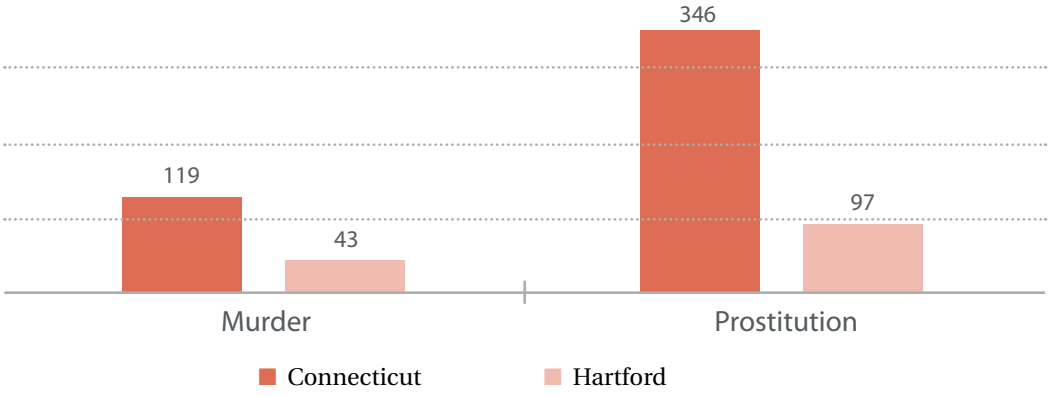
rate of arrests in the city could either indicate that crimes are more prevalent or that more effective law enforcement approaches have been implemented. Nevertheless, according to the 2009 Uniform Crime Report from the Connecticut Department of Public Safety, over one third of all murder arrests in Connecticut occurred in Hartford. Moreover, almost 20% of the state's drug abuse violations occur in the city. Other violent crimes that occur more frequently in the Hartford than in the state are simple assault and disorderly conduct.

Figure 7. **Percent of All Crimes in Hartford and Connecticut (2009)**




Over 70% of Key Informants rated neighborhood safety in Hartford as "Poor" or "Very Poor." Given the opportunity to define a healthy community, one Key Informant stated that it should be "a community where individuals and families would choose to live [and one that can] provide a quality of life that is safe and engaged. People are being physically healthy, not being subject to lead poisoning and toxic things. Violence and noise pollution are not issues." Unfortunately, this community scenario is not widely available for the majority of Hartford residents, but community safety has multiple measures and Hartford experienced proportionally less crime than the state on infractions involving larceny/theft, gambling, liquor laws, and driving under the influence.

Figure 8. **Crime in Hartford and Connecticut (2009)**



In 1982, Wilson and Kelling introduced the broken windows theory to explain urban disorder and vandalism on crime and anti-social behavior [6]. The appearance of the environment can suggest what is acceptable, with a disordered environment implying that behaviors that are usually unacceptable can be perpetrated without fear of consequences. And although this theory has been met with criticism cities such as New York and Albuquerque have implemented policy shifts to address "quality of life" issues and have seen improvements in the overall community security and decreases in crime. Generally speaking, a safer community is synonymous with a healthier community.

Hartford has taken strides to address its issue with violence in the city. Since the re-instatement of the Shooting Task Force in 2011, shootings have decreased by 35% [7]. Although the partnership with neighboring cities, the Connecticut State Police, and the Office of the Attorney General has been effective in reducing shootings, a more comprehensive approach in crime intervention is needed. The City of Hartford is also making a concerted effort to improve the condition of its neighborhoods through the implementation of the Livable and Sustainable Neighborhoods Initiative. As part of this initiative, city government is partnering with homeowners and other neighborhood stakeholders throughout the city to address blighted properties and revitalize Hartford's sense of community. By addressing the needs of some of Hartford's most vulnerable areas, the city is taking proactive steps to rebuild its infrastructure, reduce crime, and restore hope.

## Environmental Quality

The environment where we live, work and play; the quality of the air we breathe; the water we drink – all of these have an impact on our health. While individual education and behavior change are important to improving health, the real power in making progress on health is in changing the environment and systems that structure and affect our world.

The HEI measures the relative environmental burden of Connecticut's municipalities by using specific Federal Toxic Release Inventory data, examining levels of locally generated air and water pollution, and industrial density. These two measures are positively correlated with employment opportunities; however, they are however negatively correlated with health outcomes. Hartford receives an average score (4) in the Health Equity Index for both the number of facilities reporting and the total air emissions in pounds. Total water discharge and waste stream in pounds, measures of water pollution, are strong indicators of localized pollution levels, and Hartford has high levels of both. These two measures strongly correlated with the chlamydia and gonorrhea rates.

While potential relationships between high STD rates and a high environmental burden may initially seem attenuated at best, both act as a highly reliable indication of a marginalized neighborhood impacted by blighted property and compromised opportunities for fulfillment. Strong correlations between two seemingly distinct and independent realms such as environment and STDs speak to the vast array of various social and health burdens underserved communities bear disproportionately.

## Civic Involvement

According to the HEI, Hartford receives the lowest possible score in terms of civic involvement. Civic involvement impacts health because it is a direct measure of social equity, activism and sustainability of a community; the HEI indicates a strong correlation of low civic involvement with infectious diseases, accident/violence, childhood illness, and life expectancy.

Table 7. **Health Indicators Related to *Civic Involvement***

| | INDEX SCORE | CORRELATION COEFFICIENT |
|---|---|---|
| Infectious Disease | 2 | 0.59 |
| Accident/Violence | 3 | 0.57 |
| Childhood Illness | 1 | 0.51 |
| Life Expectancy | 3 | 0.50 |
| Mental Health | 2 | 0.45 |
| Cardiovascular | 3 | 0.42 |
| Health Care Access | 2 | 0.42 |
| Liver Disease | 2 | 0.33 |
| Renal Disease | 2 | 0.32 |
| Respiratory Illness | 4 | 0.31 |
| Diabetes | 3 | 0.29 |
| Perinatal Care | 3 | 0.29 |

**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

Communities with demonstrated social cohesiveness are more likely to have greater resources and support networks, which would allow for improved health outcomes. Approximately 45% of Hartford's adult residents are registered to vote indicating that an inadequate proportion of the community selects state and municipal government officials. Several factors may prevent an individual from registering to vote including a lack of motivation, frustration with current leaders, or language or cultural barriers. In order to increase the number of registered voters, community-based education initiatives should be employed and should focus on demonstrating to individual residents that they are valued members of the community, and that their vote does in fact make a difference.

## Community Food Security

Although not identified as a social determinant of health within the HEI, food security plays a vital role in urban settings like Hartford. While there are 14 medium and large grocery store retailers in the city, corner markets, convenience stores, and fast-food outlets are far more abundant, making a healthy diet difficult to maintain. Pre-packaged and prepared foods are more readily available at such establishments, and their lack of fresh and healthy foods can contribute to various poor health outcomes. In response to this deficiency, the City of Hartford, in partnership with farmers and community-based organizations, is working to

increase the number of farmers' market in the city. In 2011, there were 6 certified farmers' markets in the city accepting grant funds from the Women, Infants and Children federal program and its supplemental nutrition program, the Farmers' Market Nutrition Program. Furthermore, three of the markets were certified to accept Supplemental Nutrition Assistance Program benefits, which helped low-income people and families buy the food necessary for good health.

A report distributed by the University of Connecticut College of Agriculture and Natural Resources found that the presence of food retail resources were not significantly associated with community food security but income and lack of transportation that limit access to food are significantly associated. Despite high numbers of families enrolled in public food assistance, towns with greater rates of households headed by females or the elderly, or lack of education experience greater rates of food insecurity [8].

Foods that are highly processed contain both trans fats and refined sugars, and can lead to both diabetes and heart disease by increasing weight and cholesterol levels. The healthy food shopping choices available to Hartford residents are limited, and signal poor community health. More attention is needed for the overall food system components, including a greater focus on nutrition and cooking skills development.

# VII. Health Indicators

As part of the assessment process, Key Informants were asked to rank the **five most significant health issues** in the City of Hartford. The respondents could choose from a list of 25 health issues as well as suggest their own that were not on the list. The five most identified – obesity, diabetes, mental illness, heart disease, and asthma – consisted of four health issues from the list and one write–in response.Mortality statistics are also noted in this section and infectious disease was included due in part to the unique age distribution of Hartford.

This section will also highlight how Hartford rates low in community health when compared to other Connecticut municipalities. As a result of its relatively low standing, this assessment focuses on a Hartford neighborhood comparative using city–specific indexing from the HEI in order to gain a richer understanding of city health concerns. The health outcomes included here are Life Expectancy, Mortality, Infant Mortality, Infectious Diseases, Respiratory Illness, Obesity/Heart Disease, Diabetes, and Mental Health.

## Life Expectancy

Percent of deaths for the City of Hartford due to any of the top 10 causes of death in the U.S. are overall smaller when compared to the state and nation. The strongest positive determinant correlations with life expectancy are education, economic security, and civic involvement; with Hartford rating very low in each (HEI index of 2, 2, and 1, respectively).

Table 8. **Social Determinants of Health Related to *Life Expectancy***

| | INDEX SCORE | CORRELATION COEFFICIENT |
|---|---|---|
| Education | 2 | 0.64 |
| Economic Security | 2 | 0.61 |
| Civic Involvement | 1 | 0.50 |
| Community Safety | 1 | 0.41 |
| Employment | 3 | 0.35 |
| Environmental Quality | 4 | 0.34 |
| Housing | 3 | 0.31 |

**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

Table 9. **Top 10 Leading Causes of Death for Hartford, Connecticut and the U.S. (ranked from most to least common for Hartford; 2005-2007)**

| | CITY OF HARTFORD | CONNECTICUT | U. S. |
|---|---|---|---|
| Heart Disease | **24.2%** | 25.6% | 25.4% |
| Malignant Neoplasms (Cancer) | **18.2%** | 23.8% | 23.1% |
| Accidents (Unintentional Injuries) | **5.5%** | 4.2% | 4.8% |
| Stroke (Cerebrovascular Disease) | **4.8%** | 5.2% | 5.5% |
| Chronic Lower Respiratory Diseases | **3.7%** | 4.9% | 5.3% |
| Diabetes | **3.4%** | 2.6% | 3.1% |
| Septicemia | **2.6%** | 2.1% | 1.4% |
| Influenza/Pneumonia | **2.4%** | 2.9% | 2.2% |
| Nephritis, Nephrotic Syndrome, and Nephrosis (Kidney Disease) | **2.3%** | 1.9% | 1.9% |
| Alzheimer's Disease | **1.2%** | 2.6% | 2.9% |

However, the age-adjusted mortality rate (AAMR; defined as a death rate that controls for the effects of differences in population age distributions.) for all causes of death for the city is notably larger than that of the state and nation (876 compared to 692 and 778, respectively). With a younger population, this dramatic difference in the age-adjusted rate suggests that the mortality rate for older populations in Hartford is very high even though the elderly population itself may not be very large. Therefore, deaths due to heart disease and cancer low compared to the state and the U. S.

The Years of Potential Life Lost (YPLL; defined as an estimate of the average years a person would have lived if he or she had not died prematurely.) for Hartford was 10,647 per 100,000 for 2005-2007 for all causes of death. HEI scores Hartford 2 for YPLL. This measure correlated inversely with obtaining a bachelor's degree, and having a higher median household income and median value for owner occupied housing. It had a reverse effect for adults with less than a 9th grade education, so the lower level of education, the greater the years of potential life lost.

Infant/neonatal mortality is a major concern for Hartford; the mortality rates in Hartford for infants and neonates are markedly greater than those across Connecticut and the United States. Upon further examination, there is a pronounced disparity among infant deaths for infants of different races and ethnicities in Hartford; from 2001 through 2008, the mortality rate for Black infants was consistently higher than either the white or Hispanic infant mortality rate.

Figure 9. **Infant and Neonatal Mortality Rates* for Hartford, Connecticut, and the U.S. (2006)**

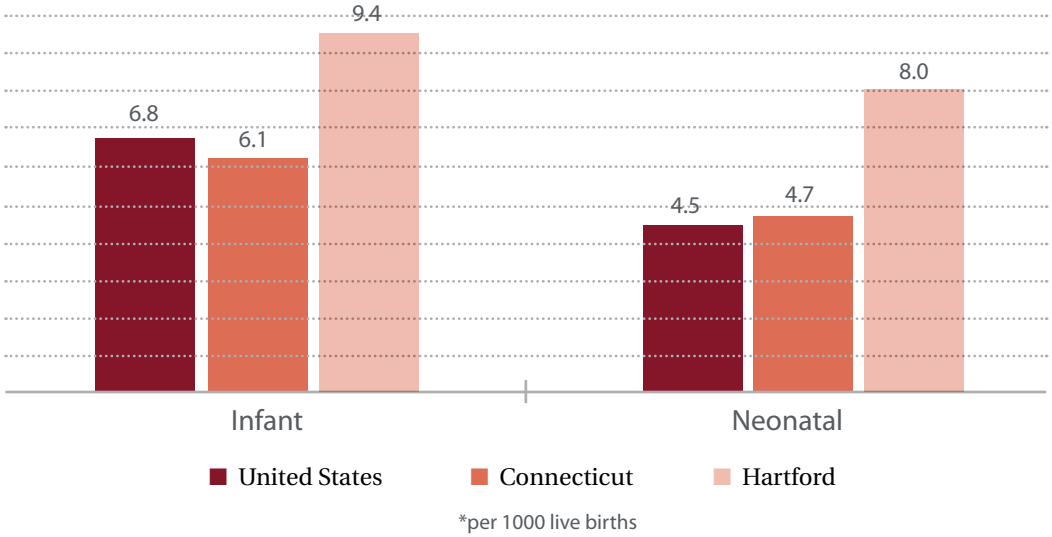
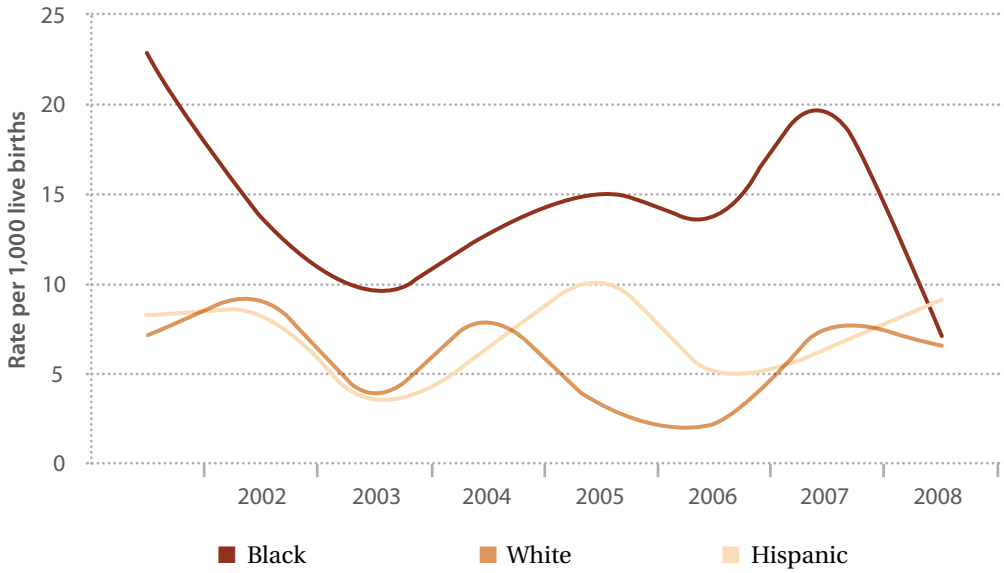
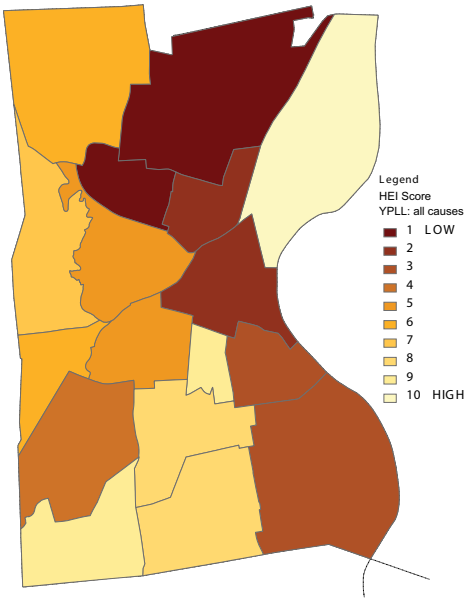



Figure 10. **Infant Mortality Rates by Race/Ethnicity, Hartford, CT (2001-2008)**




These adverse infant health outcomes greatly contribute to a lower than average life expectancy in Hartford. The following map highlights how its neighborhoods compare to each other with regard to the YPLL measure; the darker colors indicate a lower rating (greater number of years) for potential life lost. Six out of 15 neighborhoods (excluding the North and South Meadows neighborhoods) rated low on the YPLL. Per the HEI, the Northeast and Upper Albany neighborhoods were the lowest rated of all Hartford neighborhoods.

Map 3. **HEI Years of Potential Life Loss (YPLL) Score: All Causes by Neighborhood**




## Infectious Diseases

In the state of Connecticut, there is a strong correlation of infectious disease with multiple social determinants, as demonstrated in Table 10.

Table 10. **Social Determinants of Health Related to *Infectious Disease***

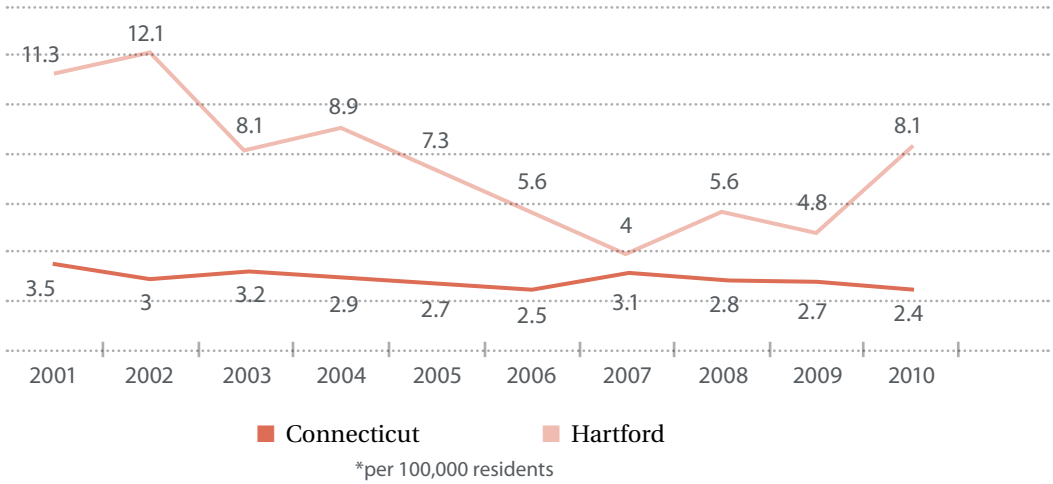
| | INDEX SCORE | CORRELATION COEFFICIENT |
|---|---|---|
| Community Safety | 1 | 0.67 |
| Education | 2 | 0.59 |
| Environmental Quality | 4 | 0.59 |
| Civic Involvement | 1 | 0.59 |
| Economic Security | 2 | 0.58 |
| Housing | 3 | 0.55 |
| Employment | 3 | 0.28 |

**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

There is particular concern when examining **HIV** trends in the city. From 2002 through 2009 per the Connecticut Department of Public Health HIV Surveillance Program, the number of HIV infection cases declined for the city; however, there has been a 221% increase of new HIV infections among self-reporting men who have sex with men over the same time period, as well as a 123% increase in new infections amongst Hartford's Black residents.

There is an established correlation between HIV rates and rates of tuberculosis infection [9]; however, that does not seem to be the case in Hartford. Data from the Connecticut Department of Public Health's Tuberculosis Control Program shows that while tuberculosis rates in Connecticut are in decline, tuberculosis rates in Hartford are increasing.

Figure 11. **Tuberculosis Prevalence* in Hartford and Connecticut (2004-2010)**




The Connecticut Department of Public Health's STD Control Program provides information on infections more commonly associated with reproductive health. From 2007-2010, a total of 7768 cases of **chlamydia** were reported in Hartford (rate of 157 per 10,000 residents), which is almost 1.5 times higher than the next highest rate of chlamydia infection in the state. Among Blacks and Latinos, the rates were 12.1 and 5.3 times higher than those for whites, respectively. Of all the diagnoses reported during this period, approximately 70% of the cases were among 15 to 24-year olds; Black and Latino female adolescents and young adults accounted for about 36% and 20%, respectively, of all reported chlamydia cases during this same period.

**Gonorrhea** is the second most commonly reported STI in Hartford after chlamydia. Between 2007 and 2010, approximately 20% of the total reported cases of gonorrhea in the state occurred in Hartford (a rate of 40.5 per 10,000 residents). The rate of infection of women when compared to men was 1.5 times higher (119 versus 78 per 10,000 residents, respectively). Blacks and Latinos also had a disproportionate rate of infection when compared to whites (15.3 and 4.1 times greater, respectively); infection rates were also the highest for 15- to 24-year olds.

Since 2008 the prevalence of **syphilis** in Hartford has increased from 4.1 to 10.5 cases per 100,000 residents; and approximately 94% of all reported cases were male. A racial and ethnic disproportion is also reflected, as African American and Latino male rates were 9.2 and 4.3 times higher than white males, respectively.

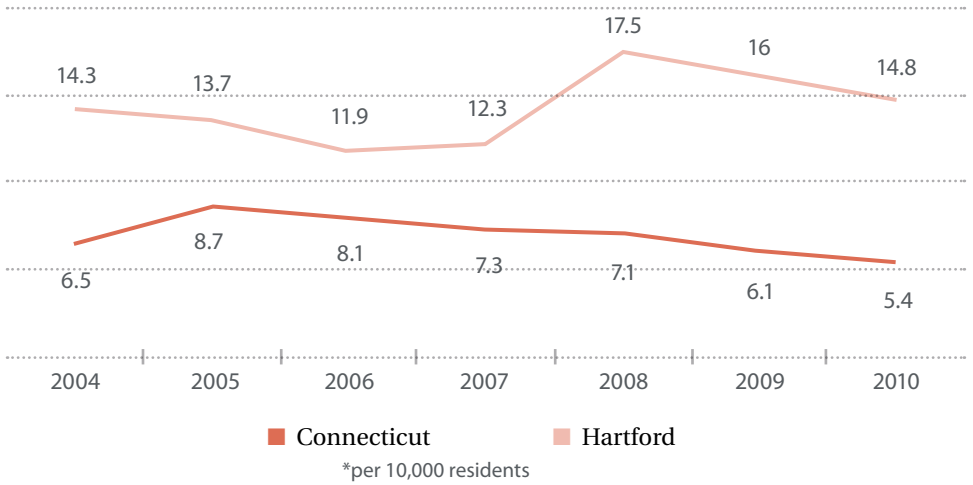
Table 11. **Syphilis in Hartford among Males by Age Category (2007-2010)**

| | PERCENT INFECTED |
|---|---|
| 15-24 years old | 34% |
| 25-34 years old | 10% |
| 35-44 years old | 41% |

During this same time period, syphilis prevalence among males 25-34 year old increased 81% to 32 cases per 100,000; and among males 35-44 years old it increased 51% to 79 cases per 100,000.

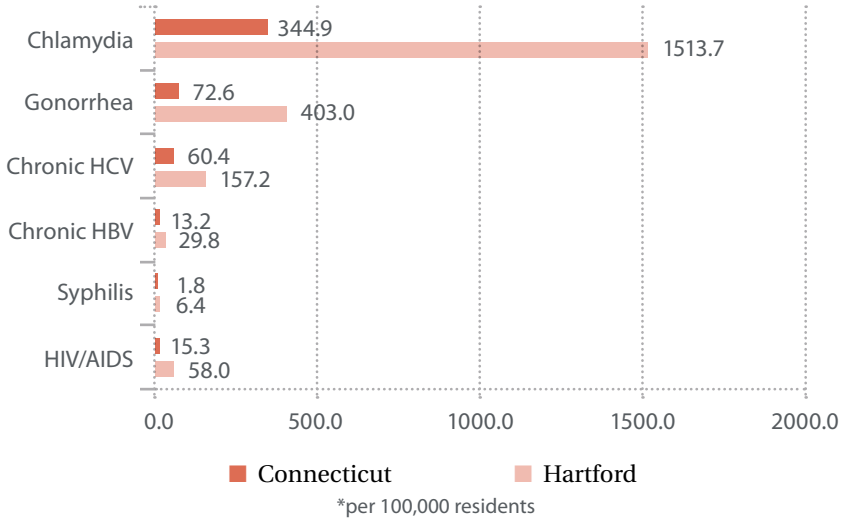
The information concerning **Hepatitis C** (HCV) for the state and the city is limited. From the data available, chronic HCV rates in Hartford have been declining for the past 3 years, yet they still remain 2.7 times greater than the state prevalence.

Figure 12. **Chronic HCV Prevalence* in Hartford and Connecticut (2004-2010)**



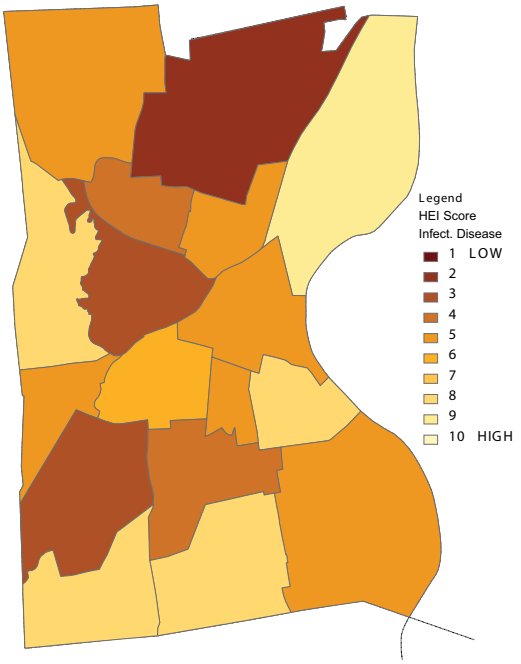

With these disproportionate rates of infection, it is not surprising that when compared to the state the city's HEI rating is 2 for all infectious diseases. The following displays a summary of how the city rates when looking at some of the infectious disease trends:

Figure 13. **Infectious/Communicable Diseases Prevalence* in Hartford and Connecticut (2009)**




Using data from Connecticut's Department of Public Health, a comparison of how Hartford's neighborhoods compare to each other with regard to infectious diseases is demonstrated in the following map using the same HEI rating system; the Northeast rated lowest out of 17 total neighborhoods.

Map 4. **HEI Infectious Disease Score by Neighborhood**



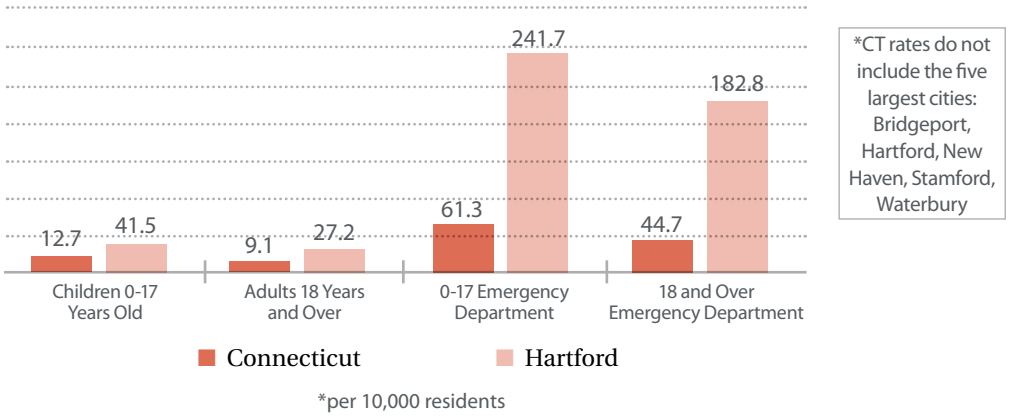
Based on secondary data analysis, Hartford has considerably higher rates of preventable infectious/communicable diseases than the state with the exception of Lyme disease.

The Department of Health and Human Services and the Consortium can identify the prevalence of infectious diseases and provide resources to those who are in most need. The Department's division of Disease Prevention and Health Promotion has both an STD and TB clinic, as well as an HIV program, all geared to curtail infection rates and keep Hartford residents informed and educated. The federal government has passed legislation that provides for individuals who live with HIV/AIDS affordable, high-quality HIV care and related services. For those who are already established Ryan White consumers, there is a network of agencies and area providers that are connected to the city and in position to provide needed services and resources.

## Respiratory Illness

Based on data gathered in the Secondary Data Profile, asthma is an area of concern for the community. According to the Connecticut Department of Health, the hospitalization rates for asthma are notably higher for Hartford when compared to the state as seen in the following figure.

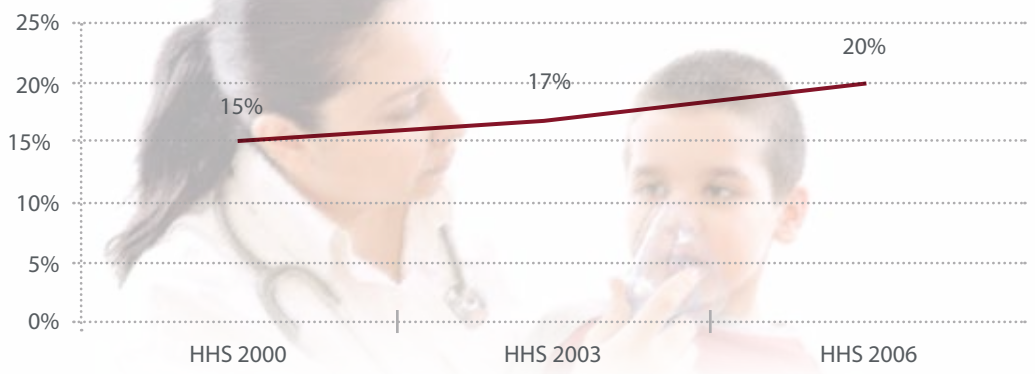
Figure 14. **Asthma Hospitalization Rates* in Hartford and Connecticut (2009)**




*per 10,000 residents

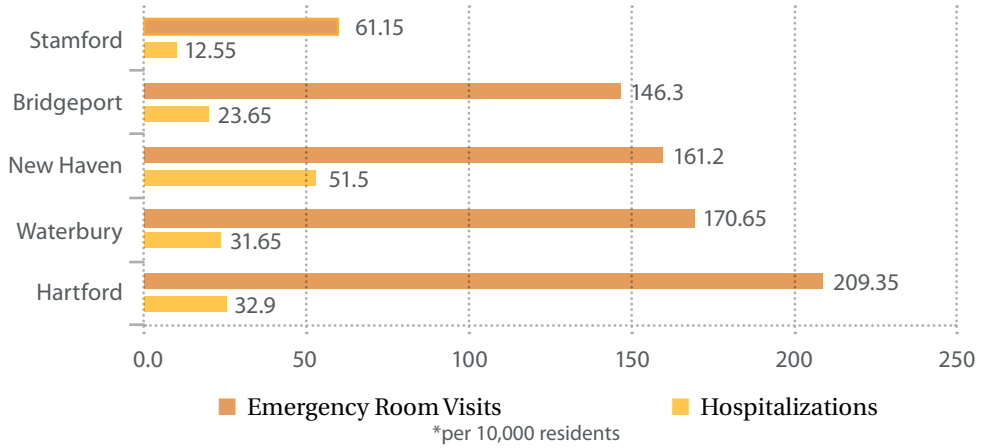
In 2006, the self-reported responses of current asthma among adults were 20%. This is the highest percentage of self-reported asthma in the past three Hartford Health Surveys, an HHS survey conducted through community partners every three years to gauge resident health and access to health care.

Figure 15. **Percent of Self-Reported Asthma from Hartford Health Survey (2006)**




Regardless of how residents self-report, Hartford has the highest rate of emergency room usage (209 ER visits for every 10,000) and the second highest rate of hospitalization for asthma as the primary cause of diagnosis (33 admissions per 10,000) when compared to other major Connecticut cities.

Figure 16. **Asthma Hospitalizations and Emergency Room Visit Rates* for All Residents by Connecticut City (2001-2007)**




Similar to asthma hospitalization rates, mortality rates are also an area of concern when compared to the rest of the state. The asthma-related mortality rate for men in Hartford is 22.4 per 10,000 men compared to 7.9 for the rest of Connecticut. Similarly, the mortality rate for women in Hartford is 42.5 compared to Connecticut's rate of 16.5.

In general, respiratory illness in Hartford has some moderate correlations, as noted in the following table, but the HEI indexed score is very low for each of the social determinants correlated to respiratory illness.

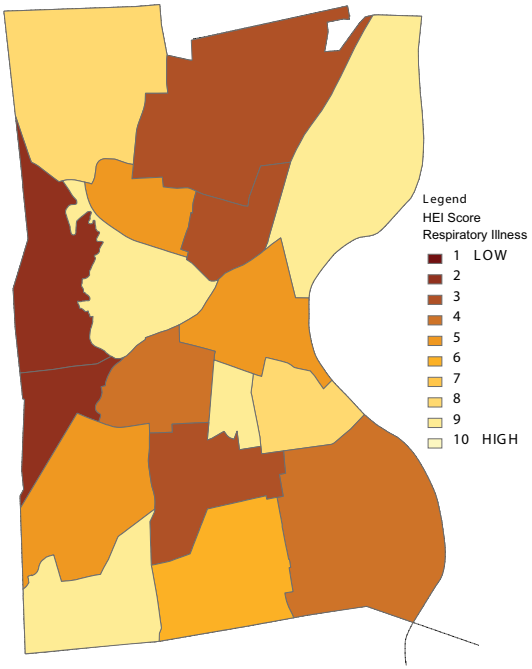
Table 12. **Social Determinants of Health Related to *Respiratory Illness***

| | INDEX SCORE | CORRELATION COEFFICIENT |
|---|---|---|
| Economic Security | 2 | 0.45 |
| Education | 2 | 0.41 |
| Civic Involvement | 1 | 0.31 |
| Housing | 3 | 0.29 |
| Employment | 3 | 0.28 |
| Community Safety | 1 | 0.26 |
| Environmental Quality | 4 | 0.18 |

**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

Using Connecticut Department of Health Office of Vital Records data, the HEI scores Hartford an overall indexed score of 4 when compared to other Connecticut towns and cities. The following map gives an indication of where the lowest scores lie when comparing among Hartford's neighborhood; the West End and Parkville neighborhoods ranked the lowest among Hartford neighborhoods with regard to respiratory health.

Map 5. **HEI Respiratory Illness Score by Neighborhood**



To help address these issues, the Asthma Call to Action Taskforce, a coalition of representatives from Hartford's Department of Health and Human Services, public schools, area hospitals, community organizations, and other agencies that are concerned about asthma in Hartford, seek to increase awareness about asthma to its residents, improve asthma care, establish a network of individuals and organizations to provide education and resources, and define asthma rate improvement strategies.

## Obesity and Cardiovascular Disease

The percentages of obese Connecticut adults 20 years and older are notably higher for the Black and Hispanic populations (39.8% and 29%, respectively) than the state's white population (20.6%) [10]. Obesity is most commonly measured as a percentage of body fat based on height and weight. The following table shows the percent of healthy, overweight, and obese adults in the UnitedStates for all income levels as determined by the National Health and Nutrition Examination Survey. These weight category trends are similar when looking solely at people who are classified as "poor" (those who lived below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22, 314 for a family of four) by the US government. With a high rate of unemployment and a low HEI ranking for economic security, it can be assumed that obesity trends in Hartford are similar and that there is an increased relative risk for hypertension and adverse cardiovascular outcomes [11]."

Table 13. **United States Weight Categories**

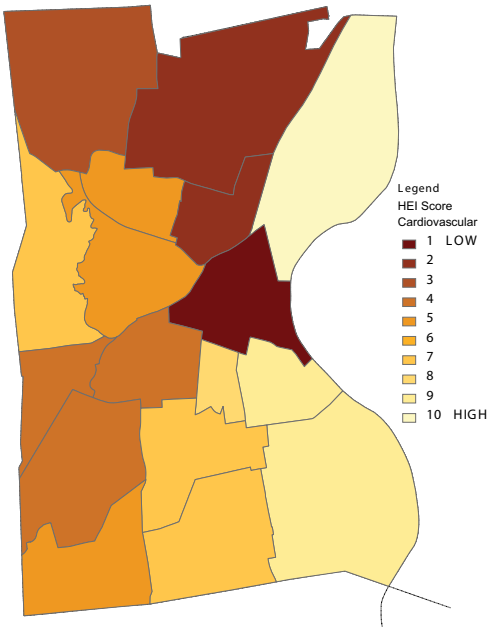
| | HEALTHY WEIGHT | OVERWEIGHT | OBESE |
|---|---|---|---|
| 1988-1994 | 41.9% | 33.0% | 22.7% |
| 2001-2004 | 32.4% | 34.7% | 31.2% |
| 2005-2008 | 30.9% | 33.5% | 33.9% |

Similar rates emerge when looking at people who are classified as "poor" by the US government (those who live below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22,314 for a family of 4). With high rates of unemployment and a low HEI rating for economic security in Hartford, this trend is most likely mirrored in the city.

Downtown, the neighborhood with the lowest residential density, has the highest economic security and education scores, as well as the largest proportion of white residents. Despite such a low percentage of Hartford residents living Downtown, the fact that this population enjoys greater employment as well as health care coverage contributes to an increase in cardiovascular diagnoses and ultimately prevents undesirable health outcomes. For the remainder of Hartford's residents, cardiovascular health indicators remain elusive.

Obesity has been linked to both cardiovascular health and diabetes [12], and heart disease was the leading cause of death for Hartford from 2005 to 2007. The Northeast and Frog Hollow neighborhoods rate the poorest for these two significant risk factors.

Map 6. **HEI Cardiovascular Disease Score by Neighborhood**




There are several strong and moderate correlations with cardiovascular health, the top being education and economic security; below is a table listing the top five.

Table 14. **Social Determinants of Health Related to *Cardiovascular Health***

| | INDEX SCORE | $R_S$ VALUE |
|---|---|---|
| Education | 2 | 0.51 |
| Economic Security | 2 | 0.48 |
| Civic Involvement | 1 | 0.42 |
| Environmental Quality | 4 | 0.36 |
| Community Safety | 1 | 0.33 |
| Housing | 3 | 0.29 |
| Employment | 3 | 0.28 |

**Note: All shown correlations are statistically significant and ranked in order from strong to weak.**

## Diabetes

The fact that diabetes often presents as a co-morbidity with other diseases, it is difficult to segregate the information for just diabetes. The following table shows the age-adjusted percentages for adults 20+ for selected ethnic groups throughout the state; the data are from the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS).

Table 15. **Connecticut Residents with Diabetes by Race**

| YEAR | ALL ADULTS | NON-HISPANIC WHITE | NON-HISPANIC BLACK | MEXICAN-AMERICAN |
|---|---|---|---|---|
| 2005 | 7.2% | 6.6% | 14.3% | 15.1% |
| 2006 | 6.9% | 6.4% | 15.0% | 10.4% |
| 2007 | 8.3% | 7.1% | 20.4% | 13.5% |
| 2008 | 7.2% | 6.2% | 16.1% | 11.6% |
| 2009 | 6.8% | 6.4% | 13.0% | 9.7% |
| 2010 | 7.6% | 7.0% | 13.9% | 9.5% |

The rates are alarmingly higher for non-Hispanic Blacks, and Hispanics; these trends are the same across all economic levels, and substantially higher for those who live below and near the poverty threshold. Since 2007, there has been a significant improvement in these high rates as both the Black and Hispanic populations in the state have experienced a drop in the rate of diabetes, but there is still a diabetes health disparity drawn along racial lines for the state.

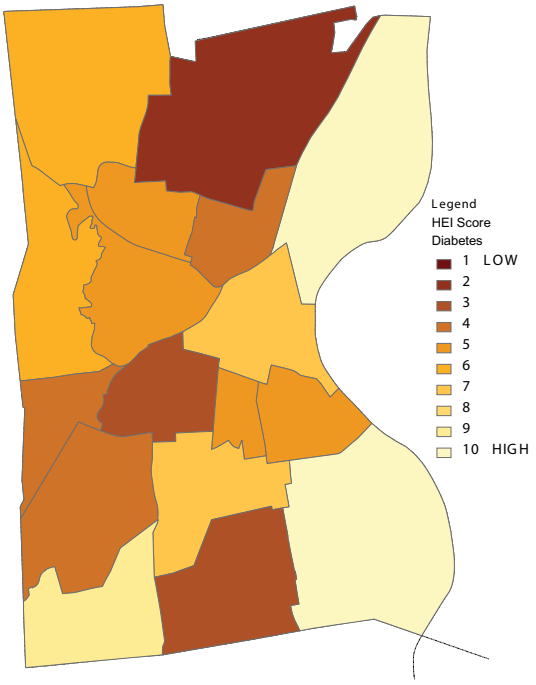
While Hartford's diabetes rate is lower than the state's, the CDC indicates that Hartford's rate is on the rise. If the state trend in diabetes is any indication of how the city is afflicted by this disease, then the assumption would be that the Black population is disproportionately affected when compared to other racial/ethnic groups.

Figure 17. **Diabetes in Hartford for Adults**

Source: US Dept of Health and Human Services, The Office on Women's Health

The neighborhoods are compared to one another in the following map using the HEI indexing giving an indication where in Hartford diabetes is more of a health issue. The Northeast neighborhood ranks the lowest among Hartford neighborhoods.

Map 7. **HEI Diabetes Score by Neighborhood**

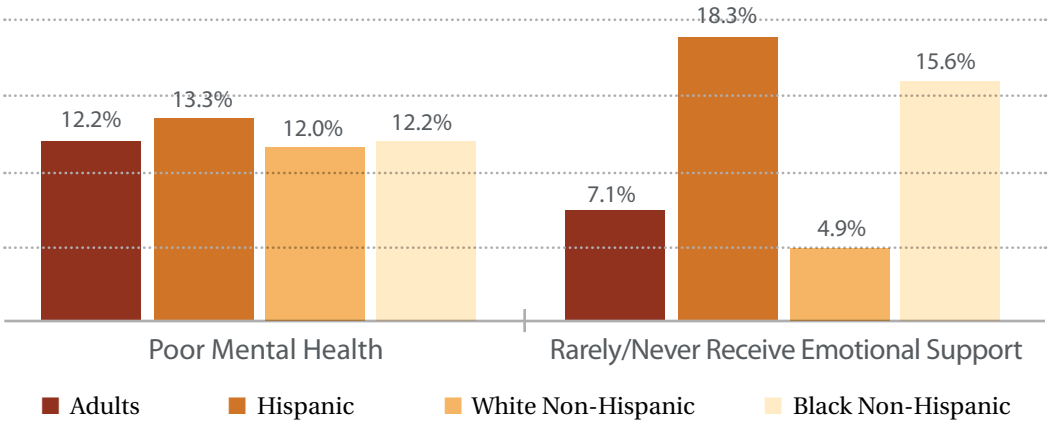



## Behavioral Health

The HEI, using discharge data from the Connecticut Hospital Association and death information from the Connecticut Office of Vital Records, calculated an aggregate index score of 2 for mental health as a health indicator for Hartford. There are several significant correlations with mental health, including community safety (Rs=0.55), economic security (Rs=0.47), environmental quality (Rs=0.45), civic involvement (Rs=0.45), education (Rs=0.42), housing (Rs=0.37), and employment (Rs=0.23). With a low-indexed social determinant score, it can be inferred mental health issues are a significant health risk for the city. The BRFSS, a national system of state-based surveys, annually assessed how the residents fare with mental health issues. The results show that there is clearly a greater rate of Hispanics and Blacks self-reporting a lack of emotional support.

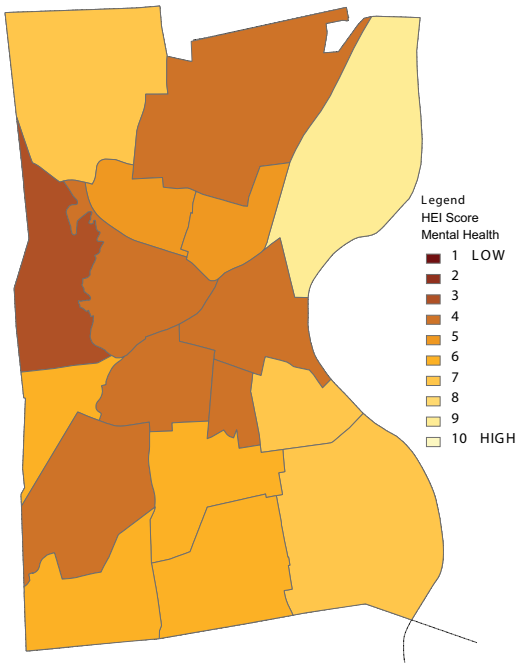
The behavioral health infrastructure is headed by the state through the Department of Mental Health and Addiction Services and its various partners; the complexity of mental health services designed to cater to large geographic regions encompassing the city as well as 37 other municipalities calls for a more thorough investigation and coordinated approach. HHS is currently engaged in a collaborative partnership that includes planning for a Behavioral Health Needs Assessment in order to fully understand the nature of these services.

Figure 18. **Mental Health in Connecticut (Age Adjusted; 2007-2009)**




The neighborhood with the highest utilization of mental health services is the West End, which happens to be relatively affluent when compared to other city neighborhoods. The Consortium could hypothesize that individuals with greater access to specialized health care services would experience higher rates of diagnoses.

Map 8. **HEI Mental Health Score by Neighborhood**



# VIII. Barriers to Services

The Urban Alliance survey asked respondents to consider barriers to health services and community resources. The most commonly reported barriers to service areas included not knowing about existing services (27%), lack of available services (22%), not able to pay (20%), and lack of transportation (20%).

Respondents were also asked to identify the most crucial **perceived service needs** for Hartford. Areas perceived as the most in need of additional services included homelessness/ housing (45%), education (41%), job training/employment assistance (39%), and basic needs/food assistance (36%). The top **actual service needs** were determined by respondents indicating that someone in their household would benefit from having additional service in this area. This resident survey found that the actual needs of the respondents were, for the most part, similar to the perceived needs of Hartford; three of the top five needs mentioned were common to both (see table below; ranked by most common responses and common responses bolded). The two areas - perceived and actual service needs - were explored separately to note differences, but with such high correlations in Connecticut between employment, education, and housing, as well as other factors, the overlap between the two areas is not as discordant as they appear to be.

Table 16. **Top 5 Needs for Hartford**

| ACTUAL NEEDS | PERCEIVED NEEDS |
|---|---|
| Basic needs/food assistance services | Homelessness/housing |
| Financial support services | Education |
| Job training/employment assistance | Job training/employment assistance |
| Health and wellness | Basic needs/food assistance |
| Education | Youth development |

The Key Informant interviews completed by the Consortium had similar findings. More than half of Key Informants chose either "Disagree" or "Strongly Disagree" with positive statements about access to care regarding dental services, medical specialists, a comprehensive model of primary care, providers who accept Medicaid, transportation, and health care delivery in Hartford.

Table 17. **Key Informant Perceptions of Health Care**

| ACCESS/ BARRIERS TO CARE | "DISAGREE" OR "STRONGLY DISAGREE" |
|---|---|
| The majorities of Hartford residents are able to access and afford a dentist when needed. | 88% |
| The majority of Hartford residents are able to access needed medical specialists. | 83% |
| The majorities of Hartford residents are able to access and afford a primary care provider. | 76% |
| Transportation to medical appointments is available to residents when needed. | 73% |
| The healthcare delivery system in Hartford has a comprehensive approach to patient care. | 71% |
| There is a sufficient number of providers accepting Medicaid or other forms of medical assistance. | 70% |
| There is a sufficient number of bilingual healthcare providers in Hartford. | 63% |

# IX. Conclusions

This Community Health Needs Assessment was assembled to give readers an overview of Hartford public health trends and to provide a platform to increase the communication across non-governmental as well as governmental agencies to improve the lives of city residents. The findings from this process demonstrate that Hartford residents include high concentrations of people at an increased risk for unhealthy living. After examining all the data sources used to create this report – the Key Informant Survey, the Hartford Survey Project, and the various secondary data that were analyzed – it is clear that marginalized and underserved populations are overrepresented in the city, and the need for establishing and expanding effective partnerships among city agencies is critical. Poverty, job opportunities, education, quality of housing, and neighborhood safety are quality of life measures that were most often mentioned by the Key Informants. All of these were highlighted in the data as areas where collaboration and renewed effort are necessary.

According to a recent model created by the University of Wisconsin's Population Health Institute, at least half of community wellness is driven by non-health factors such as education, housing, and pollution [13]. Connecticut, consistently one of the wealthiest states in the union, is also home to some of the nation's most significant gaps in leading societal determinants of health. For instance, when looking at poverty, Latinos are 4.7 times and Blacks are almost 3.6 times more likely to be living in poverty when compared with their white counterparts in Connecticut. These poverty rates among Black and Latino population reflect, in part, the terribly high unemployment rates in cities like Hartford, which have been crippled by unemployment rates at least 50% higher than that of the state. Coupled with things like a high percentage of single parent households with children present, these compromising circumstances make it difficult for Hartford residents and their families to achieve optimal health.

In addition to a high concentration of poverty, this assessment identifies other actionable non-medical factors that drive the state of health in Hartford. **Education**, for example, is a key indicator for economic security; low educational attainment coupled with limited employment opportunities adversely impact economic security of the city on a whole. Hartford's battle is a difficult one as one-third of Hartford adults do not have a high school diploma. And with one-fifth of the city's labor force unemployed and a high rate of service occupations for those who are employed, it is apparent that when people get off on the wrong foot, the path to occupations with increased responsibility and higher wages become all the more difficult.

The **housing** situation in Hartford makes it difficult to find up-to-date accomodations. The housing stock in Hartford is an aging one, where more than half of the housing available for both renters and buyers was built prior to 1950. And of all the housing occupied, less than a quarter of Hartford residents own their domicile; the majority has to choose from these old housing options.

**Crime** continues to be a problem in Hartford. With such a high number of youth living in the city, there is going to be an increased rate of violent and injury-related deaths. The city, having about 3.5% of the entire state's population, accounts for more than a third of all murders. In addition, there are some very specific health issues that should be highlighted:

- High age-adjusted mortality rates despite a population that is relatively young suggest that the senior population is dying at a high rate
- The diabetes rate, although well below Connecticut's rate, has climbed steadily in recent years
- As a percent of the total population in Hartford, residents who are obese are increasing while the percent of healthy weight adults declines
- The infant mortality rate in Hartford is much higher than Connecticut and the United States

Preventing problems before they arise is a particularly powerful tool in population health. These prevention efforts will result in a dramatic cost savings and reduction in social problems to our community. In 2009, the Mayor's office in collaboration with HHS designed and launched the Healthy Hartford wellness campaign, focused on many aspects of daily life in our urban environment. The goal of this campaign is to increase the availability of health related information and have community discussions designed to influence the choices that the Hartford citizenry at all ages makes regarding health behaviors like physical activity, proper eating, and other aspects of disease prevention. HHS launched a set of creative teams to design high-impact activities and approaches targeting all residents; the Healthy Hartford campaign was recently recognized by the U.S. Surgeon General and received the *Healthy Youth for a Healthy Future Champion Award* for its efforts to curb and prevent childhood overweight and obesity within our community. The Healthy Hartford campaign along with its many partners strives to reach the largest possible number of residents by designing interactive activities that target specific demographic groups throughout Hartford's 17 neighborhoods.

The Healthy Hartford campaign is a collaborative effort with area health providers and organizations to promote healthy choices and solutions to health problems by focusing efforts on a specific segment of the population or aspect of living in Hartford (i.e., youth, women, and men; Hartford workforce; and public policies that affect the health of the people). As an example, the recently formed Hartford Childhood Wellness Alliance draws on the combined leadership and expertise of community and professional groups across a spectrum of public health, medicine, academia, child care, and recreation to address the critical issue of childhood health and weight in Hartford. The Alliance provides a structure through which individuals and organizations can join together in the common interest of creating healthy environments for children and families, which in turn would be a cost saver to the city. Early in 2011, the Society of Actuaries calculated that the total economic cost of overweight and obesity in the United States is $270 billion per year as a result of an increased need for medical care, loss of worker productivity due to higher rates of death, loss of productivity due to disability of active workers, and loss of productivity due to total disability. Providing increased accurate chronic

disease self-management training to Hartford residents would have a positive impact on total cost to the city.

Collaboration holds the promise of allowing progress on issues where multiple parties are involved. Sustaining collaborations in Hartford is possible not only because of established partnerships but also because of efforts like such as this needs assessment, which will further strengthen existing relationships by highlighting where the major needs are. Any local health department is limited by available resources. Therefore, HHS' standard operating procedure is to constantly search for, and partner with, other organizations in order to better the lives of Hartford's citizenry.

The Public Health Advisory Council, a city charter-supported advisory panel, is an example of a sustained collaboration relative to residential health and chronic disease. Members of the panel include high-level representation from area hospitals, the Hispanic Health Council, the State of Connecticut Department of Mental Health and Addiction Services, the Connecticut Association of Directors of Health, and other community health organizations, and has regularly met for approximately the last 15 years. As experts on community health, the Public Health Advisory Council advices the city on many public health policies and initiatives.

In order to have improved collaborations throughout the city, there needs to be better data exchange among health organizations. Both health and societal data are not consistently collected, are difficult to compare longitudinally, and frequently may not tell the whole story. To improve the health of Hartford residents, HHS and its partners must have access to accurate local data. There are opportunities to make significant improvements in gathering and tracking such data on all of these issues, particularly on the issues of chronic diseases and risk factors that contribute to health disparities. It is imperative that those working in public health and providers of direct clinical services collaborate to develop a strategic plan for delivery of health care (including preventive care and mental health services) in a manner best suited to the community being served.

This report has presented a case that trends in health outcomes are determined not just by individual-level factors such as genetic make-up or access to medical services. Rather, these rates are a result of but also social, political, and environmental conditions. At the population level, major influences on health are structural. Throughout the development of this report, it has become clear that the disproportionate rates of morbidity and mortality borne by the city's marginalized communities result from far more than access to medical services, a result of cumulative social and environmental conditions in which Hartford's low-income residents are born, grow up, live and work. Hartford stakeholders can no longer afford to ignore evidence linking social determinants of health with health outcomes. By building on the analysis in this report and partnerships throughout the city, Hartford will take significant steps to build the capacity to understand and address the conditions contributing to the compromised health of our most vulnerable neighborhoods.

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# XI. Appendix

## A. Agencies that participated with the Key Informant Interviews:

| | |
|---|---|
| Alcohol and Drug Recovery Centers, Inc. | Family Life Education |
| Asian Family Services (CRT) | Gay and Lesbian Health Collective |
| Blue Hills Civic Association | Greater Hartford Interdenominational Ministerial Alliance, Inc. |
| Boys and Girls Clubs | Greater Hartford Interfaith Coalition for Equity and justice |
| Cancer Program at Hartford Hospital | Hartford 2000 |
| Capital Workforce Partners | Hartford Behavioral Health |
| Capitol Region Education Council | Hartford Community Schools |
| Casey Family Services | Hartford Foundation for Public Giving |
| Catholic Charities (Archdiocese of Hartford) | Hartford Hospital |
| Catholic Worker House | Hartford Office of Youth Services |
| Charter Oak Health Center | Hartford Public Schools |
| Child Health and Development Institute of Connecticut, Inc. | Hispanic Health Council |
| Children's Trust Fund | Immaculate Conception Shelter and Housing Corp. |
| Clay Arsenal Neighborhood Revitalization Zone | Injury Prevention Center at CCMC |
| Commission on Children | Institute for Community Research |
| Community Health Service | Institute for Hispanic Families s |
| Community Renewal Team, Inc. (CRT) | Interval House |
| Conference of Churches | Khmer Health Advocates |
| Connecticut Children's Medical Center (CCMC) | Latino Community Services |
| Connectikids | Malta House of Care, Inc. |
| CT African-American Affairs Commission | My Sister's Place |
| CT Association of Directors of Health (CADH) | Office for Young Children (COH) |
| CT Association of Human Services | Pediatric Clinic at Saint Francis Hospital |
| CT Coalition for Environmental Justice | Saint Francis Hospital |
| CT Department of Mental Health and Addiction Services | The Village for Families and Children |
| CT Department of Public Health | UConn Health Center |
| CT Department of Social Services | UConn School of Social Work |
| CT Voices for Children | United Way |
| Daughters of Eve | Urban League of Greater Hartford |
| Department of Community Outreach at Saint Francis Hospital Wellness | Easy Breathing at the Hartford Alliance for Childhood |
| Emergency Department at Hartford Hospital | Women's League Child Development Center |

## B. Key Informant Survey

### City of Hartford 2010 Key Informant Survey

Good morning/afternoon, my name is _____ and I'm calling on behalf of the City of Hartford Department of Health and Human Services, CCMC, Saint Francis Hospital and Hartford Hospital. You should have received a letter from those institutions soliciting your participation in a brief survey that is part of a community needs assessment for the City of Hartford. You should have received a survey in advance to help us in this process; if that is not the case I could send one now and schedule for a latter time.

Do you have approximately 15-20 minutes to complete the survey with me? If not, I would be glad to schedule a time that is convenient with your schedule and call you back.

Please know that all of your responses will be held in strict confidence. No individual from the sponsoring organizations will have access to your individual survey. I'd like to emphasize that I am not an employee of the City of Hartford, but am affiliated with Holleran, a research firm located in Lancaster, Pennsylvania commissioned to conduct this research.

### DEMOGRAPHICS

**Area of Expertise:**
**Education Level:**
**Years providing services:**

1. What is your vision of a healthy community?

2. What are the most significant barriers that residents of Hartford face when they attempt to access healthcare?

3. What specific populations in Hartford do you feel are not being adequately served by the healthcare system?

_____

_____

_____

4. In your opinion, what proportion of the population in Hartford views the hospital emergency room as their key source of primary care? _____%

## Key Health Issues

1. In your opinion what are the five most significant health issues (most severe or most serious) you perceive in your community. The first one being the least important and the last one being the most important.

*Caller: Read the list only if respondent needs prompting.*

| | |
|---|---|
| ☐ Diabetes | ☐ Substance Abuse |
| ☐ Cancer | ☐ Mental Illness |
| ☐ Heart Disease | ☐ Domestic/Family Violence |
| ☐ Stroke | ☐ Abuse of Children |
| ☐ Obesity | ☐ Sexually Transmitted Diseases – does not include HIV/AIDS |
| ☐ Daily Life Stressors | ☐ HIV/AIDS |
| ☐ Reproductive Health | ☐ Violence |

Other _____

2. In your opinion what would be the best way to promote health prevention and wellness?

3. Regarding health and well-being, what needs of Hartford residents are currently begin met the best?

4. Regarding health and well-being, what would you say are the greatest unmet needs among residents of Hartford?

5 If you had to identify two key improvements that you feel are needed to provide better healthcare for area residents, what would they be?

a. _____

b. _____

**Comments regarding Key Health Issues:**

_____

_____

_____

_____

## Quality of Life

1. On a scale of 1 (very poor) through 5 (excellent), please rate each of the following within the community.

**1 = very poor; 2 = poor; 3 = average; 4 = good; and 5 = excellent.**

| NEIGHBORHOOD/ENVIRONMENT | Very poor « » Excellent |
|---|---|
| a. Availability of recreational activities | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| b. Neighborhood safety | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| c. Clean, litter-free neighborhoods | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| d. Water or air pollution | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| e. Quality of housing (affordable, in good condition) | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| f. Road/traffic conditions | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| g. Schools/education | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| h. Job opportunities | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| i. Availability of care for children | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| j. Poverty | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |

**Do you have any additional comments on Quality of Life or any example that illustrates your answers:**

2. What specific suggestions do you have for area hospitals and public health agencies to improve the quality of life in the community?

## Quality of Care

1. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements.

**1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree**

| HEALTHCARE | Strongly disagree « » Strongly agree |
|---|---|
| a. There are a sufficient number of bilingual providers in Hartford. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| b. The majority of residents in the area are able to access a primary care provider. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| c. The majority of residents in the area are able to access a medical specialist. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| d. The majority of residents in the area are able to access a dentist when needed. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| e. Transportation for medical appointments is available to the majority of residents. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| f. There are a sufficient number of providers accepting Medicaid or other forms of medical assistance. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |

**Do you have any additional comments on Healthcare or any example that illustrates your answers:**

| SOCIAL SERVICES | Strongly disagree « » Strongly agree |
|---|---|
| a. The majority of the residents in Hartford would know where to go if they needed mental health/ behavioral health treatment. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| b. The majority of residents in Hartford would know where to go if they needed help with a substance abuse problem. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| c. There are a sufficient number of behavioral health providers in the area. | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| d. The healthcare delivery system in Hartford has a holistic approach to patient care? | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |

**Do you have any additional comments on Social Services or any example that illustrates your answers:**

That concludes the survey. Thank you very much for your time today and we appreciate your feedback!

## C. Hartford Resident Survey: English

**URBAN ALLIANCE**

# HARTFORD RESIDENT SURVEY

URBANALLIANCE

*You are being invited to complete this survey because you are a Hartford resident. We are interested in learning about services that would be helpful to you and your family as well as barriers to receiving these services. It is our hope that the results of this survey will enhance and increase services offered in the city of Hartford.*

### QUESTIONS ABOUT YOU

*This survey begins with questions about you and your family. These help us to describe who completed the survey.*

**1. Do you live in the city of Hartford?**
☐ Yes ☐ No
*Please provide your Zip Code:*_____

**2. What is your ethnicity?**
☐ Latino ☐ West Indian ☐ Multi-ethnic
☐ White ☐ African American ☐ Other
☐ Asian *Specify:*_____

**3. What is your gender?** ☐ Female ☐ Male

**4. Do you attend a church?**
☐ Yes *If yes, please specify which church:*
☐ No _____

**5. How many adults live in your household?** _____

**6. How many children live in your household?**_____

**7. Check the box that best describes your age:**
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

### QUESTIONS ABOUT SERVICES IN HARTFORD

*In the **first column (questions a & b),** indicate if you or someone in your household (someone who lives with you) would benefit from additional services in each area and barriers to receiving each type of service.*

*In the **second column (question c),** rank (1 through 3) the three areas most in need of additional services in the city of Hartford. Place the ranking in the box corresponding to each service area (1 indicates the area most in need of additional services). Complete this column after you have completed the first column (questions a & b) for each type of service.*

**1. SUBSTANCE ABUSE RECOVERY** *(e.g. treatment, prevention)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access substance abuse recovery services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

*c. Rank the three areas most in need of additional services in Hartford* ☐

**2. BASIC NEEDS/FOOD ASSISTANCE** *(e.g. food pantry, meals, clothing, utility assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access basic needs/food services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**3. HOMELESSNESS/HOUSING** *(e.g. emergency shelter, affordable housing)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access housing services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**4. COUNSELING/EMOTIONAL SUPPORT** *(e.g. counseling, support group, stress management)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access counseling/emotional support services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

*c. Rank the three areas most in need of additional services in Hartford* ☐

**5. YOUTH DEVELOPMENT** *(e.g. leadership training, mentoring, after-school programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access youth development services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**6. HEALTH AND WELLNESS** *(e.g. health care, screenings)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access health and wellness services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

*c. Rank the three areas most in need of additional services in Hartford* ☐

**7. EDUCATION** *(e.g. tutoring, GED classes, ESL, literacy)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access education services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**8. FINANCIAL SUPPORT SERVICES** *(e.g. personal finance planning, financial literacy, tax preparation)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access financial support services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**9. ELDERLY SERVICES** *(e.g. convalescent home, meals, senior center/programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access services for seniors? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**10. PRISONER /RE-ENTRY SERVICES** *(e.g. visitation, re-entry assistance, support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access prisoner/re-entry services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**11. JOB TRAINING/EMPLOYMENT ASSISTANCE** *(e.g. skill development, resume assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access job training/employment services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

**12. PREGNANCY/PARENTING SUPPORT** *(e.g. parenting/prenatal education and support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

*b. Which factors make it difficult to access pregnancy/parenting support services? (mark all that apply)*

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves _____

*c. Rank the three areas most in need of additional services in Hartford* ☐

## D. Hartford Resident Survey: Spanish

**ALIANZA URBANA**
**ENCUESTA SOBRE RESIDENTE HARTFORD**

*Usted está invitado a terminar esta encuesta porque usted es un residente de Hartford. Estamos interesados en aprender sobre los servicios que le serían provechosos a usted y su familia así como barreras para recibir estos servicios. Nuestra meta es mejorar y aumentar el alcance de los servicios ofrecidos en la ciudad de Hartford.*

**PREGUNTAS DE USTED**

*Esta encuesta comienza con preguntas sobre usted y su familia y nos ayudan a describir quién terminó la encuesta.*

**1. ¿Usted vive en la ciudad de Hartford?**
☐ Sí ☐ No
*Proporcione por favor su Código postal:*_____

**2. ¿Cuál es su pertenencia étnica?**
☐ Latino ☐ Oeste Indio ☐ Multi-étnico
☐ Blanco ☐ Africano ☐ Otro
☐ Asiático Americano *Especifique*:_____

**3. ¿Género?** ☐ Femenino ☐ Masculino

**4. ¿Usted asiste a alguna iglesia?**
☐ Sí *Especifique por favor qué iglesia:*
☐ No _____

**5. ¿Cuántos adultos viven en su casa?** _____

**6. ¿Cuántos niños viven en su casa?**_____

**7. ¿Está entre las edades de?:**
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

**PREGUNTAS SOBRE SERVICIOS EN HARTFORD**

*En la **primera columna** (preguntas a y b), indique si usted o alguien en su hogar serían beneficiado por servicios adicionales en cada área y también indique las barreras para recibir cada tipo de servicio.*

*En la **segunda columna** (pregunta c), Marque (1 a 3) las tres áreas más necesitadas de servicios adicionales en la ciudad de Hartford. Marque la caja que corresponde a cada área de servicio (1 indica la área más en necesidad de servicios adicionales). Termina esta columna después de que usted haya terminado la primera columna (preguntas a y b) para cada servicio.*

**1. RECUPERACIÓN DEL ABUSO DE LA SUSTANCIA** *(e.g. tratamiento, prevención )*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen dificil de tener acceso a sevicios de recuperacion del abuso de la sustancia?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de niños ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguística ☐ Sin seguro medico
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos ☐ Otro:

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**2. NECESIDADES BASICAS/ASISTENCIA DE ALIMENTOS** *(e.g. despensa de alimento, ropa, ayuda para utilidades)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen dificil de tener acceso a sevicios de necesidades basicas/asistencia de alimentos?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguística ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**3. PERSONAS SIN HOGAR/VIVIENDA** *(e.g. abrigo de emergencia, cubierta comprable )*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen dificil de tener acceso a sevicios de personas sin hogar/vivienda?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguística ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**4. ASESORAMIENTO/APOYO EMOCIONAL** *(e.g. asesoramiento, grupo de ayuda)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen dificil de tener acceso a sevicios de asesoramiento/apoyo emocional?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguística ☐ Sin seguro medico
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos ☐ Otro:

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**5. DESARROLLO DE LA JUVENTUD** *(e.g. programas después de la escuela)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen difícil de tener acceso a sevicios de desarrollo de la juventud?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**6. SALUD Y BIENESTAR** *(e.g. cuidado médico, examenes )*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen difícil de tener acceso a sevicios de salud?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Sin seguro medico
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos ☐ Otro:

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**7. EDUCACIÓN** *(e.g. tutoria, GED, ESL)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*¿Qué factores hacen difícil de tener acceso a sevicios de educación?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**8. SERVICIOS DE APOYO FINANCIERO** *(e.g. preparación de impuesto, planificación financiera)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen difícil de tener acceso a sevicios de?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**9. SERVICIOS ENUEJECIENTES** *(e.g. clinica de reposo, comidas, centro mayor/programas )*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen difícil de tener acceso a sevicios de enuejecientes?*

☐ **Nunca henecesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**10. SERVICIOS DE PRISIÓN Y DE REINTEGRARSE** *(e.g. visitation, ayuda del reingreso )*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen difícil de tener acceso a sevicios de re-entry del preso?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**11. ENTRENAMIENTO/BUSQUEDA DE TRABAJO** *(e.g. ayuda de resume)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen difícil de tener acceso a sevicios de asistencia trabajo de formación?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

**12. SERVICIOS DE EMBARAZO/ CRIANZA DE LOS HIJOS** *(e.g. educación y apoyo)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

*b. ¿Qué factores hacen difícil de tener acceso a sevicios del embarazos o criannza de los hijos?*

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de ninos ☐ Falta de transporación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera linguistica ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos economicos _____

*c. Marque las tres areas más necesitando adicional serivicios* ☐

## E. Data Sources for HEI Social Determinants

**Social Determinants**

Civic Involvement
Community Safety
Economic Security
Education
Employment
Environmental Quality
Housing

**Health Outcomes**

Accidents/Violence
Cancer
Cardiovascular Disease
Childhood Illness
Diabetes
Health Care Access
Infectious Disease
Life Expectancy
Liver Disease
Mental Health
Perinatal Care
Renal Disease
Respiratory Illness

For additional information about the HEI social determinants and health outcomes, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

## F. Data Sources for Health Equity Index

Connecticut Secretary of State Office Voter Registration Statistics

Connecticut Department of Public Safety Uniform Crime Reports

2008 Warren Group Residential Statistics Report

2006-07 Home Mortgage Disclosure Act, Aggregate Reports; 2006-07 FFIEC Census Reports 2006-07

Housingpolicy.org

2000 US Census

Connecticut Department of Health Vital Records

RealtyTrac website, September 2008

2008 Connecticut Department of Social Services Temporary Family Assistance Data

Connecticut Department of Education's CEDaR site

2006 US Annual Economic Census ZIP Code Business Patterns reports; 2000 US Census

Connecticut Housing Finance Authority; 2005 US Census Population Survey

1995-2006 U.S. Annual Economic Survey

2002 US Economic Census Zip Code Statistics

US Environmental Protection Agency Toxic Release Inventory Program

Connecticut Housing Finance Authority; 2005 US Census Population Survey

Connecticut Department of Health, Office of Vital Records Death Certificates; 2007 Nielsen Claritas Population Facts Demographic Report

Connecticut Department of Health Tumor Registry; 2007 Nielsen Claritas Pop-Facts Demographic Report

2005 Connecticut Hospital Association CHIME Hospital Discharge Data

Connecticut Department of Health, Lead Poisoning Prevention and Control Program

Connecticut Department of Health, Office of Vital Records Birth Certificates

Connecticut Department of Health, Sexually Transmitted Surveillance Program

For additional information about the HEI data sources, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

Design by www.influentiald.com | Alberto Bonello

CITY OF HARTFORD DEPARTMENT OF HEALTH AND HUMAN SERVICES
131 Coventry Street | Hartford, CT 06112 | T 860.757.4700

# EXHIBIT 22

# SAINT MARY'S HEALTH SYSTEM, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidated Financial Statements and
Consolidating Information

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

# Independent Auditors' Report

The Board of Directors
Saint Mary's Health System, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Health System, Inc. (the System), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, 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 U.S. generally accepted accounting principles; 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 require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on 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 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 Saint Mary's Health System, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

***Other Matter***

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for 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 audit 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 as a whole.

KPMG LLP

February 6, 2015

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

| Assets | | 2014 | 2013 |
|---|---|---|---|
| Current assets: | | | |
| Cash and cash equivalents | $ | 26,866 | 29,939 |
| Short-term investments | | 17 | 29 |
| Current portion of assets whose use is limited | | 5,948 | 8,039 |
| Accounts receivable, net of estimated uncollectibles of $8,978 in 2014 and $9,395 in 2013 | | 30,238 | 30,768 |
| Other current assets | | 7,123 | 4,834 |
| Total current assets | | 70,192 | 73,609 |
| Marketable securities | | 24,966 | 22,365 |
| Assets whose use is limited: | | | |
| By donor and held in trust by others | | 15,696 | 15,258 |
| For estimated self-insurance liability | | 41,038 | 31,394 |
| By bond indenture | | 4,321 | 4,324 |
| Other | | 6 | 6 |
| Total assets whose use is limited | | 61,061 | 50,982 |
| Less current portion of assets whose use is limited | | 5,948 | 8,039 |
| Noncurrent assets whose use is limited | | 55,113 | 42,943 |
| Property and equipment, net | | 63,374 | 64,952 |
| Other assets: | | | |
| Investments in joint venture arrangements | | 10,024 | 10,697 |
| Deferred financing costs, net | | 103 | 128 |
| Other noncurrent assets | | 241 | 241 |
| Total other assets | | 10,368 | 11,066 |
| Total assets | $ | 224,013 | 214,935 |
| **Liabilities and Net Assets** | | | |
| Current liabilities: | | | |
| Current portion of long-term obligations | $ | 2,509 | 2,490 |
| Accounts payable | | 17,369 | 20,985 |
| Salaries, wages, and payroll withholdings | | 5,643 | 4,734 |
| Due to third-party payors, net | | 783 | 6,035 |
| Accrued expenses and other current liabilities | | 14,308 | 16,486 |
| Total current liabilities | | 40,612 | 50,730 |
| Long-term liabilities: | | | |
| Long-term obligations, net of current portion | | 17,891 | 20,374 |
| Estimated self-insurance liability | | 31,814 | 21,908 |
| Pension and deferred compensation | | 72,182 | 58,823 |
| Other long-term liabilities | | 9,523 | 10,172 |
| Total long-term liabilities | | 131,410 | 111,277 |
| Net assets: | | | |
| Unrestricted | | 32,525 | 34,102 |
| Noncontrolling interest in subsidiaries | | 370 | 302 |
| Total unrestricted | | 32,895 | 34,404 |
| Temporarily restricted | | 2,415 | 2,269 |
| Permanently restricted | | 16,681 | 16,255 |
| Total net assets | | 51,991 | 52,928 |
| Total liabilities and net assets | $ | 224,013 | 214,935 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

| | | 2014 | 2013 |
|---|---|---|---|
| Revenues: | | | |
| Revenue from patient services, net of contractual allowance | $ | 279,161 | 268,899 |
| Provision for uncollectible accounts, net of recoveries | | (11,074) | (12,878) |
| Net revenue from patient services | | 268,087 | 256,021 |
| Other operating revenues | | 10,774 | 7,864 |
| Total revenues | | 278,861 | 263,885 |
| Expenses: | | | |
| Salaries and wages | | 113,553 | 108,933 |
| Employee benefits | | 28,631 | 31,305 |
| Supplies and other expenses | | 115,557 | 103,308 |
| Provision for uncollectible accounts, net of recoveries | | 7 | 8 |
| Depreciation and amortization | | 10,529 | 10,052 |
| Interest | | 1,438 | 1,598 |
| Total expenses | | 269,715 | 255,204 |
| Operating income | | 9,146 | 8,681 |
| Nonoperating gains (losses): | | | |
| Investment income, net | | 3,824 | 2,390 |
| Equity in earnings of joint ventures | | 189 | 1,170 |
| Net loss on disposal of assets | | (46) | (230) |
| Other | | (283) | (1,572) |
| Total nonoperating gains, net | | 3,684 | 1,758 |
| Excess of revenues over expenses from continuing operations | | 12,830 | 10,439 |
| Excess of revenue over expenses | | 12,830 | 10,439 |
| Net assets released from restriction for capital expenditures | | (48) | 545 |
| Capital transactions with affiliates | | (387) | (485) |
| Change in unrealized gains on marketable securities and other assets whose use is limited | | (527) | 401 |
| Change in accumulated pension charges to unrestricted net assets | | (13,377) | 20,819 |
| Increase in unrestricted net assets | $ | (1,509) | 31,719 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

| | | 2014 | 2013 |
|---|---|---|---|
| Unrestricted net assets: | | | |
| Excess of revenues over expenses | $ | 12,830 | 10,439 |
| Net assets released from restriction for capital expenditures | | (48) | 545 |
| Capital transactions with affiliates | | (387) | (485) |
| Change in unrealized gains on marketable securities and other assets whose use is limited | | (527) | 401 |
| Change in accumulated pension charges to unrestricted net assets | | (13,377) | 20,819 |
| (Decrease) increase in unrestricted net assets | | (1,509) | 31,719 |
| Temporarily restricted net assets: | | | |
| Net assets released from restriction | | (121) | (265) |
| Restricted contributions | | 267 | 165 |
| Change in net assets of Cancer Center, including releases for capital expenditures | | — | (177) |
| Increase (decrease) in temporarily restricted net assets | | 146 | (277) |
| Permanently restricted net assets: | | | |
| Net earnings on assets held in trust by others | | 1,177 | 1,653 |
| Appropriation for expenditure | | (751) | (704) |
| Increase in permanently restricted net assets | | 426 | 949 |
| (Decrease) increase in net assets | | (937) | 32,391 |
| Net assets – beginning of year | | 52,928 | 20,537 |
| Net assets – end of year | $ | 51,991 | 52,928 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

| | | 2014 | 2013 |
|---|---|---|---|
| Cash flows from operating activities: | | | |
| (Decrease) increase in net assets | $ | (937) | 32,391 |
| Adjustments to reconcile increase in net assets to net cash provided by operating activities: | | | |
| Depreciation and amortization | | 10,529 | 10,052 |
| Net loss on disposal of assets | | 46 | 230 |
| Change in unrealized (gains) losses on investments | | 527 | (401) |
| Change in net assets of Cancer Center | | — | 177 |
| Change in accumulated pension charges to unrestricted net assets | | 13,377 | (20,819) |
| Change in permanently restricted net assets | | (426) | (949) |
| Investment income, net | | (3,824) | (2,390) |
| Equity in earnings of joint ventures and partnerships | | (189) | (1,170) |
| (Increase) decrease in operating assets: | | | |
| Accounts receivable, net | | 530 | 3,317 |
| Other current assets | | (2,264) | 5 |
| Increase (decrease) in operating liabilities: | | | |
| Due to third-party payors, net | | (5,252) | (972) |
| Accounts payable and other current liabilities | | (6,671) | 2,932 |
| Estimated self-insurance liability | | 9,906 | 2,846 |
| Pension, accrued compensation, and other long-term liabilities | | (667) | 526 |
| Net cash provided by operating activities | | 14,685 | 25,775 |
| Cash flows from investing activities: | | | |
| Purchases of property and equipment | | (7,211) | (16,884) |
| Distributions from joint ventures and partnerships | | 546 | 798 |
| Investments in joint venture arrangements | | 316 | (106) |
| Change in other assets whose use is limited | | (6,258) | (2,284) |
| Change in assets held in trust by others | | 426 | 949 |
| Net decrease in investments | | (3,116) | (98) |
| Net cash used in investing activities | | (15,297) | (17,625) |
| Cash flows from financing activities: | | | |
| Decrease (increase) in assets whose use is limited by bond indentures | | 3 | (224) |
| Payments on long-term obligations | | (2,464) | (1,676) |
| Net cash used in financing activities | | (2,461) | (1,900) |
| Net increase (decrease) in cash and cash equivalents | | (3,073) | 6,250 |
| Cash and cash equivalents – beginning of year | | 29,939 | 23,689 |
| Cash and cash equivalents – end of year | $ | 26,866 | 29,939 |
| Supplemental disclosure of cash flow information: | | | |
| Cash paid during the year for interest | $ | 1,402 | 1,562 |
| Assets acquired under capital lease | | — | 600 |

See accompanying notes to consolidated financial statements.

## (1) Organization

Saint Mary's Health System, Inc. (SMHS or the System) is a not-for-profit, nonstock Connecticut holding company. It is the sole member of Saint Mary's Hospital, Inc. (the Hospital) and Saint Mary's Hospital Foundation, Inc. (the Foundation).

The Hospital is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, Scovill, Partners, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The Foundation was organized to raise funds to support the Hospital.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

## (2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

### *(a) Charity and Uncompensated Care*

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone,

measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow us to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

***(b) Education, Research and Training***

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

***(c) Wellness and Health Promotional Activities***

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

***(d) Leadership, Advocacy and Voluntarism***

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 and 20,400 hours, respectively, of service in Hospital departments.

### *(e) Dollar, Time and In-kind Donations*

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

### *(f) Other Support Services*

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

## (3) Summary of Significant Accounting Policies

### *(a) Basis of Presentation*

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

### *(b) Patient Service Revenue*

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. 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.

### *(c) Charity Care and Provision for Uncollectible Accounts*

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

### *(d) Cash and Cash Equivalents*

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The System invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

### *(e) Assets Whose Use is Limited*

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by the Hospital's wholly owned captive insurance company for professional and general liability insurance.

### *(f) Marketable Securities*

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess (deficiency) of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The System has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The System recorded $53,000 and $49,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which is included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the System which could impact the value of investments after the date of these consolidated financial statements.

### *(g) Property and Equipment*

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and

gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The System reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

### *(h) Investments In Joint Venture Arrangements*

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

### *(i) Fair Value of Financial Instruments*

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the System has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

### *(j) Net Asset Categories*

To ensure observance of limitations and restrictions placed on the use of resources available to the System, the accounts of the System are maintained in the following net asset categories:

*Unrestricted* – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

*Temporarily Restricted* – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

*Permanently Restricted* – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the System.

### *(k) Excess of Revenues over Expenses*

Excess of revenues over expenses included in the consolidated statements of operations reflects the System's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, 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). Nonoperating gains and losses, and equity in earnings of joint ventures are considered in the performance measure.

### *(l) Income Taxes*

The System, Hospital, and Foundation are tax-exempt organizations as described in Section 501(c)(3) of the Internal Revenue Code and are generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in measurement are reflected in the period in which the change in judgment occurs. The System did not recognize the effect of any income tax positions in either 2014 or 2013.

### *(m) Use of Estimates*

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

### *(n) Professional and General Liability*

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

### *(o) Recently Issued Accounting Pronouncements*

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, Health Care Entities (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

*(p)* ***Prior Year Reclassifications***

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

## (4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. 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 or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services after allowance for the years ended September 30, 2014 and 2013, is as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Gross revenue from patient services | $ | 733,919 | 670,163 |
| Contractual and other allowances | | (454,430) | (401,170) |
| Charity care | | (328) | (94) |
| Provision for uncollectible accounts, net of recoveries | | (11,074) | (12,878) |
| Net revenue from patient services | $ | 268,087 | 256,021 |

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

| | | Governmental and other third-party payors | Self-pay | Total all payors |
|---|---|---|---|---|
| Revenue from patient services, net of contractual allowances, as of September 30, 2014 | $ | 271,936 | 7,225 | 279,161 |
| Revenue from patient services, net of contractual allowances, as of September 30, 2013 | $ | 257,527 | 11,372 | 268,899 |

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

| | 2014 | 2013 |
|---|---|---|
| Medicare (including Medicare managed care) | 31.6% | 31.9% |
| Medicaid | 12.3 | 13.1 |
| Other third-party payors | 32.5 | 33.1 |
| Private pay patients | 23.6 | 21.9 |
| | 100.0% | 100.0% |

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

## (5) Regulatory and Legislative Matters

### *(a) State of Connecticut Regulatory Environment*

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

### *(b) Federal Regulatory Environment*

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 and security and privacy of health information. Government activity has increased 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. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, 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.

## (6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

| | 2014 | | | | | |
|---|---|---|---|---|---|---|
| | Total | | Less than 12 months | | 12 months or more | |
| | Fair value | Cost | Fair value | Unrealized losses | Fair value | Unrealized losses |
| Cash and cash equivalents | $ 19,021 | 19,021 | — | — | — | — |
| Corporate bonds | 12,451 | 12,428 | 1,088 | (19) | 4,653 | (163) |
| U.S. government and agency obligations | 14,177 | 14,141 | 2,926 | (16) | 1,686 | (34) |
| Mutual funds | 28,344 | 23,521 | 605 | (62) | — | — |
| Equities | 1,145 | 1,173 | 608 | (9) | — | — |
| | $ 75,138 | 70,284 | 5,227 | (106) | 6,339 | (197) |

| | 2013 | | | | | |
|---|---|---|---|---|---|---|
| | Total | | Less than 12 months | | 12 months or more | |
| | Fair value | Cost | Fair value | Unrealized losses | Fair value | Unrealized losses |
| Cash and cash equivalents | $ 2,809 | 2,809 | — | — | — | — |
| Corporate bonds | 15,837 | 16,628 | 928 | (54) | 734 | (53) |
| U.S. government and agency obligations | 13,930 | 13,135 | 3,731 | (42) | 304 | (5) |
| Mutual funds | 29,961 | 23,519 | 706 | (16) | — | — |
| Equities | 4,633 | 4,052 | — | — | — | — |
| | $ 67,170 | 60,143 | 5,365 | (112) | 1,038 | (58) |

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the System's financial instruments at fair value as of September 30, 2014 (in thousands):

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| Cash and cash equivalents | $ 18,229 | — | — | 18,229 |
| Domestic corporate bonds | — | 10,469 | — | 10,469 |
| U.S. government and agency obligations | — | 12,501 | — | 12,501 |
| Equity mutual funds | 17,635 | — | — | 17,635 |
| Fixed income mutual funds | 277 | — | — | 277 |
| Equity funds | 331 | — | — | 331 |
| Total | 36,472 | 22,970 | — | 59,442 |
| Assets held in trust by others: | | | | |
| Perpetual trust | — | — | 15,696 | 15,696 |
| Total | $ 36,472 | 22,970 | 15,696 | 75,138 |

The following table sets forth by level, within the fair value hierarchy, the System's financial instruments at fair value as of September 30, 2013 (in thousands):

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| Cash and cash equivalents | $ 2,445 | — | — | 2,445 |
| Domestic corporate bonds | — | 13,477 | — | 13,477 |
| U.S. government and agency obligations | — | 11,679 | — | 11,679 |
| Equity mutual funds | 19,508 | — | — | 19,508 |
| Fixed income mutual funds | 315 | — | — | 315 |
| Equity funds | 4,488 | — | — | 4,488 |
| Total | 26,756 | 25,156 | — | 51,912 |
| Assets held in trust by others: | | | | |
| Perpetual trust | — | — | 15,258 | 15,258 |
| Total | $ 26,756 | 25,156 | 15,258 | 67,170 |

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the System's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

| Perpetual Trust | 2014 | 2013 |
|---|---|---|
| Fair value at beginning of the year | $ 15,258 | 14,299 |
| Net realized and change in unrealized gains and losses | 1,177 | 1,653 |
| Appropriation of endowment assets for expenditure | (739) | (694) |
| Fair value at end of the year | $ 15,696 | 15,258 |

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

## (7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Land and land improvements (5–25 yrs) | $ | 7,926 | 7,343 |
| Buildings and building improvements (10–40 yrs) | | 69,714 | 69,638 |
| Equipment (3–25 yrs) | | 122,712 | 114,008 |
| Projects in process | | 394 | 1,357 |
| | | 200,746 | 192,346 |
| Less accumulated depreciation and amortization | | (137,372) | (127,394) |
| Property and equipment, net | $ | 63,374 | 64,952 |

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

## (8) Long-Term Obligations

In May 1997, the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund for the Bonds issued through CHEFA, of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds issued through CHEFA, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments | $ | 19,625 | 21,475 |
| Capital leases | | 891 | 1,531 |
| | | 20,516 | 23,006 |
| Less unamortized portion of bond discount | | (116) | (142) |
| Less current portion | | (2,509) | (2,490) |
| | $ | 17,891 | 20,374 |

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

| | | Long-term obligations | Capital leases |
|---|---|---|---|
| Year ending September 30: | | | |
| 2015 | $ | 1,960 | 549 |
| 2016 | | 2,090 | 248 |
| 2017 | | 2,215 | 94 |
| 2018 | | 2,360 | — |
| 2019 | | 2,510 | — |
| Thereafter | | 8,490 | — |
| | $ | 19,625 | 891 |
| Interest payments | | | 153 |
| | | | $ 1,044 |

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,310 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

## (9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

## (10) Unrestricted, Temporarily and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the System and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

| | Total | Controlling interest | Noncontrolling interest |
|---|---|---|---|
| Unrestricted net assets, beginning of year | $ 34,404 | 34,102 | 302 |
| Excess of revenues over expenses | 12,830 | 12,398 | 432 |
| Net assets released from restriction for capital expenditures | (48) | (48) | — |
| Transfers to affiliates | (387) | (23) | (364) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | (527) | (527) | — |
| Change in accumulated pension charges to unrestricted net assets | (13,377) | (13,377) | — |
| Unrestricted net assets, end of year | $ 32,895 | 32,525 | 370 |

The changes in consolidated unrestricted net assets attributable to the System and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

| | Total | Controlling interest | Noncontrolling interest |
|---|---|---|---|
| Unrestricted net assets, beginning of year | $ 2,685 | 2,333 | 352 |
| Excess of revenues over expenses | 10,439 | 10,084 | 355 |
| Net assets released from restriction for capital expenditures | 545 | 545 | — |
| Transfers to affiliates | (485) | (80) | (405) |
| Change in unrealized gains (losses) on marketable securities and other assets whose use is limited | 401 | 401 | — |
| Change in accumulated pension charges to unrestricted net assets | 20,819 | 20,819 | — |
| Unrestricted net assets, end of year | $ 34,404 | 34,102 | 302 |

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Cancer | $ | 212 | 196 |
| Building and equipment | | 421 | 428 |
| Community services | | 511 | 518 |
| Education | | 186 | 153 |
| Other | | 1,085 | 974 |
| | $ | 2,415 | 2,269 |

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations | $ | 15,713 | 15,287 |
| Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support: | | | |
| Hospital operations | | 818 | 818 |
| Medical education | | 150 | 150 |
| | $ | 16,681 | 16,255 |

## (11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The System's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the System has no funds designated by the Board of Directors as endowment.

The System has interpreted 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. The System 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 (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment 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 System in a manner consistent with the standard of prudence prescribed by the Act.

The System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the System and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the System, and the investment policies of the System.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Donor-restricted endowment funds at September 30, 2014 | $ | 457 | 16,681 | 17,138 |
| Donor-restricted endowment funds at September 30, 2013 | $ | 375 | 16,255 | 16,630 |

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Endowment net assets, September 30, 2013 | $ | 375 | 16,255 | 16,630 |
| Investment return: | | | | |
| Investment income | | 110 | 913 | 1,023 |
| Net appreciation (depreciation) | | (23) | 264 | 241 |
| Total investment return | | 87 | 1,177 | 1,264 |
| Appropriation of endowment assets for expenditure | | (5) | (751) | (756) |
| Endowment net assets, September 30, 2014 | $ | 457 | 16,681 | 17,138 |

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

| | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|
| Endowment net assets, September 30, 2012 | 261 | 15,306 | 15,567 |
| Investment return: | | | |
| Investment income | 96 | 789 | 885 |
| Net appreciation | 19 | 864 | 883 |
| Total investment return | 115 | 1,653 | 1,768 |
| Appropriation of endowment assets for expenditure | (1) | (704) | (705) |
| Endowment net assets, September 30, 2013 | 375 | 16,255 | 16,630 |

The System has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the System must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the System's control as to spending and investment policies.

To satisfy its long term rate-of-return objectives, the System 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 System targets a diversified asset allocation that places emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The System follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the System expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

## (12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability claims have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and subject to change. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Reserves for premiums held on deposit at beginning of year | $ | 10,544 | 6,657 |
| Current period payments from loss escrow | | 4,600 | 2,450 |
| Change in reserve for premiums held on deposit for loss portfolio transfer | | 374 | 6,673 |
| Current period payments from reserves for premiums held on deposit | | 403 | 5,236 |
| Reserves for premium held on deposit at end of year | $ | 15,115 | 10,544 |

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Balance at beginning of period | $ | 14,993 | 14,750 |
| Less reinsurance recoverable | | (2,650) | (2,300) |
| Net balance at beginning of period | | 12,343 | 12,450 |
| Incurred related to: | | | |
| Current year | | 4,547 | 4,493 |
| Prior years | | (993) | (4,034) |
| Total incurred | | 3,554 | 459 |
| Paid related to: | | | |
| Current year | | 73 | 3 |
| Prior years | | 350 | 563 |
| Total paid | | 423 | 566 |
| Net balance at end of period | | 15,474 | 12,343 |
| Add reinsurance recoverable | | 2,750 | 2,650 |
| Balance at end of period | $ | 18,224 | 14,993 |

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

## (13) Retirement Plans

### *(a) Defined Benefit Plan*

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Change in benefit obligation: | | | |
| Benefit obligation, beginning of year | $ | 124,196 | 138,482 |
| Interest cost | | 6,064 | 5,613 |
| Actuarial loss (gain) | | 17,454 | (13,726) |
| Benefits paid | | (6,786) | (6,173) |
| Benefit obligation, end of year | | 140,928 | 124,196 |
| Change in plan assets: | | | |
| Fair value of plan assets, beginning of year | | 66,215 | 59,683 |
| Actual return on plan assets | | 6,091 | 7,340 |
| Contributions | | 4,121 | 5,365 |
| Benefits paid | | (6,786) | (6,173) |
| Fair value of plan assets, end of year | | 69,641 | 66,215 |
| Funded status at year end | $ | (71,287) | (57,981) |
| Amounts recognized in consolidated balance sheets consist of: | | | |
| Noncurrent liabilities | $ | (71,287) | (57,981) |
| Accumulated charges to unrestricted net assets, consisting of net actuarial losses | | 56,338 | 42,961 |
| Net amount recognized | $ | (14,949) | (15,020) |

The net actuarial loss that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Components of net periodic benefit cost: | | | |
| Interest cost | $ | 6,064 | 5,613 |
| Expected return on plan assets | | (5,064) | (4,724) |
| Net amortization and deferral | | 3,050 | 4,477 |
| Net periodic benefit cost | | 4,050 | 5,366 |
| Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands): | | | |
| Net (loss) gain | | (10,327) | 25,296 |
| Net amortization and deferral | | (3,050) | (4,477) |
| (Decrease) increase recognized in changes to unrestricted net assets | | (13,377) | 20,819 |
| (Decrease) increase to unrestricted net assets associated with recognized net periodic benefit costs and (charge) credit to accumulated pension charge | $ | (17,427) | 15,453 |

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

| | 2014 | 2013 |
|---|---|---|
| Weighted average assumptions at September 30: | | |
| Discount rate for benefit obligations | 4.55% | 5.02% |
| Discount rate for net periodic benefit cost | 5.02 | 4.15 |
| Expected return on plan assets | 8.00 | 8.00 |

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.



(Continued)

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

| | | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|---|
| Money market funds | $ | 2,241 | — | — | 2,241 |
| Domestic corporate bonds | | — | 12,827 | — | 12,827 |
| U.S. government and agency obligations | | — | 261 | — | 261 |
| Equity mutual funds | | 47,991 | — | — | 47,991 |
| Fixed income mutual funds | | 6,321 | — | — | 6,321 |
| Total | $ | 56,553 | 13,088 | — | 69,641 |

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

| | | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|---|
| Money market funds | $ | 1,745 | — | — | 1,745 |
| Domestic corporate bonds | | — | 14,443 | — | 14,443 |
| U.S. government and agency obligations | | — | 291 | — | 291 |
| Equity mutual funds | | 44,545 | — | — | 44,545 |
| Fixed income mutual funds | | 4,747 | — | — | 4,747 |
| Preferred equity securities | | — | 444 | — | 444 |
| Total | $ | 51,037 | 15,178 | — | 66,215 |

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

The following benefit payments are expected to be paid (in thousands):

| | | |
|---|---|---|
| 2015 | $ | 7,408 |
| 2016 | | 7,574 |
| 2017 | | 7,848 |
| 2018 | | 8,196 |
| 2019 | | 8,422 |
| 2020 through 2022 | | 45,151 |
| | $ | 84,599 |

### *(b) Defined Contribution Plan*

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

### *(c) Supplemental Pension Plan*

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

## (14) Leases and Rental Expenses

Rental expense aggregated approximately $6,147,000 and $5,982,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

| | | |
|---|---|---|
| Fiscal year: | | |
| 2015 | $ | 3,208 |
| 2016 | | 2,429 |
| 2017 | | 1,654 |
| 2018 | | 1,349 |
| 2019 | | 1,186 |
| 2020 and thereafter | | 5,253 |
| | $ | 15,079 |

## (15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried on the equity basis, and the carrying value is

approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

## (16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

## (17) Investments in Joint Venture Arrangements

***Naugatuck Valley MRI Limited Partnership***

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

## (18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Investment income related to short-term investments and investments for self-insurance | $ | 671 | 543 |
| Net assets released from restriction | | 46 | 68 |
| Contributions | | 561 | 658 |
| Cafeteria | | 1,170 | 1,173 |
| Outside services | | 545 | 274 |
| State grants | | 656 | 742 |
| Parking fees | | 232 | 320 |
| Day care | | 718 | 665 |
| Rentals | | 1,242 | 1,263 |
| Meaningful Use | | 2,962 | 1,149 |
| Other | | 1,971 | 1,009 |
| Total | $ | 10,774 | 7,864 |



(Continued)

## (19) Functional Expenses

The System provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Health care services | $ | 225,237 | 215,207 |
| General and administrative | | 43,785 | 39,406 |
| Fundraising | | 693 | 591 |
| | $ | 269,715 | 255,204 |

## (20) Subsequent Events

The System has evaluated events through February 6, 2015, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the System's consolidated financial statements except as disclosed below.

The Hospital entered into an agreement to purchase 30.3% interest from limited partners of Naugatuck Valley MRI Limited Partnership for $700,000 in December 2014. The entity will be consolidated as a subsidiary in the consolidated financial statements going forward.

Exhibit 1

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidating Balance Sheet

September 30, 2014

(In thousands)

| | Saint Mary's Hospital, Inc. Consolidated | Saint Mary's Hospital Foundation Inc. | Saint Mary's Health System Inc. | Eliminations | Saint Mary's Health System, Inc. Consolidated |
|---|---|---|---|---|---|
| Current assets: | | | | | |
| Cash and cash equivalents | $ 25,797 | 1,069 | — | — | 26,866 |
| Short-term investments | 17 | — | — | — | 17 |
| Current portion of assets whose use is limited | 5,948 | — | — | — | 5,948 |
| Accounts receivable, net | 30,196 | 42 | — | — | 30,238 |
| Other current assets | 6,612 | 15 | 520 | (24) | 7,123 |
| Total current assets | 68,570 | 1,126 | 520 | (24) | 70,192 |
| Marketable securities | 20,803 | 4,163 | — | — | 24,966 |
| Assets whose use is limited: | | | | | |
| By donor and held in trust by others | 15,696 | — | — | — | 15,696 |
| For estimated self-insurance liability | 41,038 | — | — | — | 41,038 |
| By bond indenture | 4,321 | — | — | — | 4,321 |
| Net interest in Foundation | 5,182 | — | — | (5,182) | — |
| Other | 6 | — | — | — | 6 |
| Total assets whose use is limited | 66,243 | — | — | (5,182) | 61,061 |
| Less current portion of assets whose use is limited | 5,948 | — | — | — | 5,948 |
| Noncurrent assets whose use is limited | 60,295 | — | — | (5,182) | 55,113 |
| Property and equipment, net | 62,371 | 4 | 999 | — | 63,374 |
| Other assets: | | | | | |
| Investments in joint venture arrangements | 10,024 | — | — | — | 10,024 |
| Deferred financing costs, net | 103 | — | — | — | 103 |
| Other noncurrent assets | — | — | 241 | — | 241 |
| Total other assets | 10,127 | — | 241 | — | 10,368 |
| Total assets | $ 222,166 | 5,293 | 1,760 | (5,206) | 224,013 |



(Continued)

Exhibit 1

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidating Balance Sheet

September 30, 2014

(In thousands)

| | Saint Mary's Hospital, Inc. Consolidated | Saint Mary's Hospital Foundation, Inc. | Saint Mary's Health System Inc. | Eliminations | Saint Mary's Health System, Inc. Consolidated |
|---|---|---|---|---|---|
| Current liabilities: | | | | | |
| Current portion of long-term obligations | $ 2,509 | — | — | — | 2,509 |
| Accounts payable | 17,252 | 87 | 30 | — | 17,369 |
| Salaries, wages, and payroll withholdings | 5,643 | — | — | — | 5,643 |
| Due to third-party payors, net | 783 | — | — | — | 783 |
| Accrued expenses and other current liabilities | 14,308 | 24 | — | (24) | 14,308 |
| Total current liabilities | 40,495 | 111 | 30 | (24) | 40,612 |
| Long-term liabilities: | | | | | |
| Long-term obligations, net of current portion | 17,891 | — | — | — | 17,891 |
| Estimated self-insurance liability | 31,814 | — | — | — | 31,814 |
| Pension and deferred compensation | 72,182 | — | — | — | 72,182 |
| Other long-term liabilities | 9,523 | — | — | — | 9,523 |
| Total long-term liabilities | 131,410 | — | — | — | 131,410 |
| Net assets (deficit): | | | | | |
| Unrestricted | 30,795 | 1,923 | 1,730 | (1,923) | 32,525 |
| Noncontrolling interest in subsidiaries | 370 | — | — | — | 370 |
| Total unrestricted | 31,165 | 1,923 | 1,730 | (1,923) | 32,895 |
| Temporarily restricted | 2,415 | 2,291 | — | (2,291) | 2,415 |
| Permanently restricted | 16,681 | 968 | — | (968) | 16,681 |
| Total net assets | 50,261 | 5,182 | 1,730 | (5,182) | 51,991 |
| Total liabilities and net assets | $ 222,166 | 5,293 | 1,760 | (5,206) | 224,013 |

See accompanying independent auditors' report.

Exhibit 2

**SAINT MARY'S HEALTH SYSTEM, INC.**

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

| | Saint Mary's Hospital, Inc. Consolidated | Saint Mary's Hospital Foundation, Inc. | Saint Mary's Health System Inc. | Eliminations | Saint Mary's Health System, Inc. Consolidated |
|---|---|---|---|---|---|
| Revenues: | | | | | |
| Revenue from patient services, net of contractual allowance | $ 279,161 | — | — | — | 279,161 |
| Provision for uncollectible accounts, net of recoveries | (11,074) | — | — | — | (11,074) |
| Net revenue from patient services | 268,087 | — | — | — | 268,087 |
| Other operating revenues | 9,776 | 998 | 156 | (156) | 10,774 |
| Total revenues | 277,863 | 998 | 156 | (156) | 278,861 |
| Expenses: | | | | | |
| Salaries and wages | 113,207 | 308 | 38 | — | 113,553 |
| Employee benefits | 28,620 | — | 11 | — | 28,631 |
| Supplies and other expenses | 115,262 | 377 | 74 | (156) | 115,557 |
| Provision for uncollectible accounts | — | 7 | — | — | 7 |
| Depreciation and amortization | 10,455 | 1 | 73 | — | 10,529 |
| Interest | 1,438 | — | — | — | 1,438 |
| Total expenses | 268,982 | 693 | 196 | (156) | 269,715 |
| Operating income (loss) | 8,881 | 305 | (40) | — | 9,146 |
| Nonoperating gains (losses): | | | | | |
| Investment income, net | 3,824 | — | — | — | 3,824 |
| Equity in earnings of joint ventures | 189 | — | — | — | 189 |
| Change in net assets of Foundation | 281 | — | — | (281) | — |
| Net loss on disposal of assets | (46) | — | — | — | (46) |
| Other | (283) | — | — | — | (283) |
| Total nonoperating gains, net | 3,965 | — | — | (281) | 3,684 |
| Excess (deficiency) of revenues over (under) expenses | 12,846 | 305 | (40) | (281) | 12,830 |
| Net assets released from restriction for capital expenditures | (48) | (5) | — | 5 | (48) |
| Capital transactions with affiliates | (363) | — | — | (24) | (387) |
| Change in unrealized gains on marketable securities and other assets whose use is limited | (527) | (138) | — | 138 | (527) |
| Change in accumulated pension charges to unrestricted net assets | (13,377) | — | — | — | (13,377) |
| Increase (decrease) in unrestricted net assets | (1,469) | 162 | (40) | (162) | (1,509) |

See accompanying independent auditors' report.

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# SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

# Independent Auditors' Report

The Board of Directors
Saint Mary's Hospital, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Hospital, Inc. (the Hospital), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, 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 U.S. generally accepted accounting principles; 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 require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on 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 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 Saint Mary's Hospital, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

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***Other Matter***

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for 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 audit 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 as a whole.

KPMG LLP

December 22, 2014

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

| Assets | | 2014 | 2013 |
|---|---|---|---|
| Current assets: | | | |
| Cash and cash equivalents | $ | 25,797 | 28,902 |
| Short-term investments | | 17 | 29 |
| Current portion of assets whose use is limited | | 5,948 | 8,039 |
| Accounts receivable, net of estimated uncollectibles of $8,975 in 2014 and $9,392 in 2013 | | 30,196 | 30,730 |
| Other current assets | | 6,612 | 4,357 |
| Total current assets | | 68,570 | 72,057 |
| Marketable securities | | 20,803 | 18,506 |
| Assets whose use is limited: | | | |
| By donor and held in trust by others | | 15,696 | 15,258 |
| For estimated self-insurance liability | | 41,038 | 31,394 |
| By bond indenture | | 4,321 | 4,324 |
| Net interest in Foundation | | 5,182 | 4,874 |
| Other | | 6 | 6 |
| Total assets whose use is limited | | 66,243 | 55,856 |
| Less current portion of assets whose use is limited | | 5,948 | 8,039 |
| Noncurrent assets whose use is limited | | 60,295 | 47,817 |
| Property and equipment, net | | 62,371 | 63,874 |
| Other assets: | | | |
| Investments in joint venture arrangements | | 10,024 | 10,697 |
| Deferred financing costs, net | | 103 | 128 |
| Total other assets | | 10,127 | 10,825 |
| Total assets | $ | 222,166 | 213,079 |
| **Liabilities and Net Assets** | | | |
| Current liabilities: | | | |
| Current portion of long-term obligations | $ | 2,509 | 2,490 |
| Accounts payable | | 17,252 | 20,899 |
| Salaries, wages, and payroll withholdings | | 5,643 | 4,734 |
| Due to third-party payors, net | | 783 | 6,035 |
| Accrued expenses and other current liabilities | | 14,308 | 16,486 |
| Total current liabilities | | 40,495 | 50,644 |
| Long-term liabilities: | | | |
| Long-term obligations, net of current portion | | 17,891 | 20,374 |
| Estimated self-insurance liability | | 31,814 | 21,908 |
| Pension and deferred compensation | | 72,182 | 58,823 |
| Other long-term liabilities | | 9,523 | 10,172 |
| Total long-term liabilities | | 131,410 | 111,277 |
| Net assets: | | | |
| Unrestricted Hospital | | 30,795 | 32,332 |
| Noncontrolling interest in subsidiaries | | 370 | 302 |
| Total unrestricted | | 31,165 | 32,634 |
| Temporarily restricted | | 2,415 | 2,269 |
| Permanently restricted | | 16,681 | 16,255 |
| Total net assets | | 50,261 | 51,158 |
| Total liabilities and net assets | $ | 222,166 | 213,079 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

| | | 2014 | 2013 |
|---|---|---|---|
| Revenues: | | | |
| Revenue from patient services, net of contractual allowances | $ | 279,161 | 268,899 |
| Provision for uncollectible accounts, net of recoveries | | (11,074) | (12,878) |
| Net revenue from patient services | | 268,087 | 256,021 |
| Other operating revenues | | 9,776 | 6,871 |
| Total revenues | | 277,863 | 262,892 |
| Expenses: | | | |
| Salaries and wages | | 113,207 | 108,642 |
| Employee benefits | | 28,620 | 31,294 |
| Supplies and other expenses | | 115,262 | 103,072 |
| Depreciation and amortization | | 10,455 | 9,977 |
| Interest | | 1,438 | 1,594 |
| Total expenses | | 268,982 | 254,579 |
| Operating income | | 8,881 | 8,313 |
| Nonoperating gains (losses): | | | |
| Investment income, net | | 3,824 | 2,390 |
| Equity in earnings of joint ventures | | 189 | 1,170 |
| Change in net assets of Foundation | | 281 | 437 |
| Net loss on disposal of assets | | (46) | (230) |
| Other | | (283) | (1,572) |
| Total nonoperating gains, net | | 3,965 | 2,195 |
| Excess revenues over expenses | | 12,846 | 10,508 |
| Net assets released from restriction for capital expenditures | | (48) | 545 |
| Capital transactions with affiliates | | (363) | (519) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | | (527) | 401 |
| Change in accumulated pension charges to unrestricted net assets | | (13,377) | 20,819 |
| (Decrease) increase in unrestricted net assets | $ | (1,469) | 31,754 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

| | | 2014 | 2013 |
|---|---|---|---|
| Unrestricted net assets: | | | |
| Excess of revenues over expenses | $ | 12,846 | 10,508 |
| Net assets released from restriction for capital expenditures | | (48) | 545 |
| Capital transactions with affiliates | | (363) | (519) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | | (527) | 401 |
| Change in accumulated pension charges to unrestricted net assets | | (13,377) | 20,819 |
| (Decrease) increase in unrestricted net assets | | (1,469) | 31,754 |
| Temporarily restricted net assets: | | | |
| Change in net assets of Foundation | | 146 | (100) |
| Change in net assets of Cancer Center, including releases for capital expenditures | | — | (177) |
| Increase (decrease) in temporarily restricted net assets | | 146 | (277) |
| Permanently restricted net assets: | | | |
| Net earnings on assets held in trust by others | | 1,177 | 1,653 |
| Appropriation for expenditure | | (751) | (704) |
| Increase in permanently restricted net assets | | 426 | 949 |
| (Decrease) increase in net assets | | (897) | 32,426 |
| Net assets – beginning of year | | 51,158 | 18,732 |
| Net assets – end of year | $ | 50,261 | 51,158 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

| | | 2014 | 2013 |
|---|---|---|---|
| Cash flows from operating activities: | | | |
| (Decrease) increase in net assets | $ | (897) | 32,426 |
| Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities: | | | |
| Depreciation and amortization | | 10,480 | 10,003 |
| Net loss on disposal of assets | | 46 | 230 |
| Change in unrealized losses (gains) on investments | | 527 | (401) |
| Change in net interest in Foundation | | (308) | (379) |
| Change in net assets of Cancer Center | | — | 177 |
| Change in accumulated pension charges to unrestricted net assets | | 13,377 | (20,819) |
| Change in permanently restricted net assets | | (426) | (949) |
| Investment income, net | | (3,824) | (2,390) |
| Equity in earnings of joint ventures | | (189) | (1,170) |
| (Increase) decrease in operating assets: | | | |
| Accounts receivable, net | | 534 | 3,287 |
| Other current assets | | (2,255) | 125 |
| Increase (decrease) in operating liabilities: | | | |
| Due to third-party payors, net | | (5,252) | (972) |
| Accounts payable and other current liabilities | | (6,702) | 1,522 |
| Estimated self-insurance liability | | 9,906 | 2,846 |
| Pension, deferred compensation, and other long-term liabilities | | (667) | 526 |
| Net cash provided by operating activities | | 14,350 | 24,062 |
| Cash flows from investing activities: | | | |
| Purchases of property and equipment | | (7,212) | (15,479) |
| Distributions from joint ventures | | 546 | 420 |
| Investments in joint venture arrangements | | 316 | 272 |
| Change in other assets whose use is limited | | (6,258) | 106 |
| Change in assets held in trust by others | | 426 | 949 |
| Net decrease in investments | | (2,812) | (2,052) |
| Net cash used in investing activities | | (14,994) | (15,784) |
| Cash flows from financing activities: | | | |
| Change in assets whose use is limited by bond indenture | | 3 | (224) |
| Payments on long-term obligations | | (2,464) | (1,676) |
| Net cash used in financing activities | | (2,461) | (1,900) |
| Net (decrease) increase in cash and cash equivalents | | (3,105) | 6,378 |
| Cash and cash equivalents – beginning of year | | 28,902 | 22,524 |
| Cash and cash equivalents – end of year | $ | 25,797 | 28,902 |
| Supplemental disclosure of cash flow information: | | | |
| Cash paid during the year for interest | $ | 1,402 | 1,558 |
| Supplemental disclosure of noncash item: | | | |
| Assets acquired under capital lease | $ | — | 600 |

See accompanying notes to consolidated financial statements.

## (1) Organization

Saint Mary's Hospital, Inc. (the Hospital) is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital's parent holding company is Saint Mary's Health System, Inc. (SMHS). Saint Mary's Hospital Foundation, Inc. (the Foundation) was organized to raise funds to support the Hospital. SMHS is the sole member of the Hospital and the Foundation.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

## (2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

### *(a) Charity and Uncompensated Care*

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone, measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow the Hospital to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

***(b) Education, Research and Training***

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

***(c) Wellness and Health Promotional Activities***

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

***(d) Leadership, Advocacy and Voluntarism***

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 hours and 20,400 hours, respectively, of service in Hospital departments.

***(e) Dollar, Time and In-kind Donations***

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind

services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

*(f)* ***Other Support Services***

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

## (3) Summary of Significant Accounting Policies

*(a)* ***Basis of Presentation***

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

*(b)* ***Patient Service Revenue***

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. 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.

*(c)* ***Charity Care and Provision for Uncollectible Accounts***

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

*(d)* ***Cash and Cash Equivalents***

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The Hospital invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

### *(e) Assets Whose Use is Limited*

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by a wholly owned captive insurance company for professional and general liability insurance.

### *(f) Marketable Securities*

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The Hospital has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The Hospital recorded $46,000 and $43,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which are included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the Hospital which could impact the value of investments after the date of these consolidated financial statements.

### *(g) Property and Equipment*

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess (deficiency) of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Hospital reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

***(h) Investments in Joint Venture Arrangements***

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

***(i) Fair Value of Financial Instruments***

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

### *(j) Net Interest in Foundation*

The Hospital recognizes an asset for its interest in the net assets of the Foundation, which is a financially interrelated recipient organization, as defined. The change in the Foundation's net assets during 2014 and 2013 is shown separately in the accompanying consolidated statements of operations and changes in net assets. The Hospital's interest is classified as net interest in Foundation on the accompanying consolidated balance sheets.

### *(k) Net Asset Categories*

To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

*Unrestricted* – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

*Temporarily Restricted* – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

*Permanently Restricted* – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the Hospital.

### *(l) Excess of Revenues over Expenses*

Excess of revenues over expenses included in the consolidated statements of operations reflects the Hospital's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, and 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). Nonoperating gains and losses and equity in earnings of joint ventures are considered in the performance measure.

### *(m) Income Taxes*

The Hospital is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code and is generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The Hospital recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in recognition in measurement are reflected in the period in which the change in judgment occurs. The Hospital did not recognize the effect of any income tax positions in either 2014 or 2013.

### *(n) Use of Estimates*

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

### *(o) Professional and General Liability*

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

### *(p) Recently Issued Accounting Pronouncements*

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, *Health Care Entities* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

*(q)* ***Prior Year Reclassifications***

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

## (4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. 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 or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services for the years ended September 30, 2014 and 2013, is as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Gross revenue from patient services | $ | 733,919 | 670,163 |
| Contractual and other allowances | | (454,430) | (401,170) |
| Charity care | | (328) | (94) |
| Provision for uncollectible accounts, net of recoveries | | (11,074) | (12,878) |
| Net revenue from patient services | $ | 268,087 | 256,021 |

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

| | | Governmental and other third-party payors | Self-pay | Total all payors |
|---|---|---|---|---|
| Revenue from patient services, net of contractual allowances, as of September 30, 2014 | $ | 271,936 | 7,225 | 279,161 |
| Revenue from patient services, net of contractual allowances, as of September 30, 2013 | $ | 257,527 | 11,372 | 268,899 |

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

| | 2014 | 2013 |
|---|---|---|
| Medicare (including Medicare managed care) | 31.6% | 31.9% |
| Medicaid | 12.3 | 13.1 |
| Other third-party payors | 32.5 | 33.1 |
| Private pay patients | 23.6 | 21.9 |
| | 100.0% | 100.0% |

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

## (5) Regulatory and Legislative Matters

### *(a) State of Connecticut Regulatory Environment*

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

### *(b) Federal Regulatory Environment*

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 and security and privacy of health information. Government activity has increased 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. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, 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.

## (6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

| | 2014 | | | | | |
|---|---|---|---|---|---|---|
| | Total | | Less than 12 months | | 12 months or more | |
| | Fair value | Cost | Fair value | Unrealized losses | Fair value | Unrealized losses |
| Cash and cash equivalents | $ 18,630 | 18,630 | — | — | — | — |
| Corporate bonds | 11,820 | 11,807 | 1,062 | (18) | 4,559 | (162) |
| U.S. government and agency obligations | 14,023 | 13,990 | 2,926 | (16) | 1,686 | (34) |
| Mutual funds | 25,357 | 21,016 | 608 | (9) | — | — |
| Equities | 1,145 | 1,173 | 605 | (62) | — | — |
| | $ 70,975 | 66,616 | 5,201 | (105) | 6,245 | (196) |

| | 2013 | | | | | |
|---|---|---|---|---|---|---|
| | Total | | Less than 12 months | | 12 months or more | |
| | Fair value | Cost | Fair value | Unrealized losses | Fair value | Unrealized losses |
| Cash and cash equivalents | $ 2,671 | 2,671 | — | — | — | — |
| Corporate bonds | 15,083 | 15,885 | 4,668 | (274) | 734 | (53) |
| U.S. government and agency obligations | 13,769 | 12,984 | 3,731 | (42) | 304 | (5) |
| Mutual funds | 27,155 | 21,326 | 706 | (16) | — | — |
| Equities | 4,633 | 4,052 | — | — | — | — |
| | $ 63,311 | 56,918 | 9,105 | (332) | 1,038 | (58) |

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013. Excluded from the tables are unrestricted assets, held at the Foundation, whose fair value exceeded cost by $496,000 at September 30, 2014 and $587,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2014 (in thousands):

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| Cash and cash equivalents | $ 17,838 | — | — | 17,838 |
| Domestic corporate bonds | — | 9,838 | — | 9,838 |
| U.S. government and agency obligations | — | 12,347 | — | 12,347 |
| Equity mutual funds | 14,925 | — | — | 14,925 |
| Equity funds | 331 | — | — | 331 |
| Total | 33,094 | 22,185 | — | 55,279 |
| Assets held in trust by others: | | | | |
| Perpetual trust | — | — | 15,696 | 15,696 |
| Total | $ 33,094 | 22,185 | 15,696 | 70,975 |

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2013 (in thousands):

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| Cash and cash equivalents | $ 2,307 | | — | 2,307 |
| Domestic corporate bonds | — | 12,723 | — | 12,723 |
| U.S. government and agency obligations | — | 11,518 | — | 11,518 |
| Equity mutual funds | 17,017 | — | — | 17,017 |
| Equity funds | 4,488 | — | — | 4,488 |
| Total | 23,812 | 24,241 | — | 48,053 |
| Assets held in trust by others: | | | | |
| Perpetual trust | — | — | 15,258 | 15,258 |
| Total | $ 23,812 | 24,241 | 15,258 | 63,311 |

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the Hospital's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

| | 2014 | 2013 |
|---|---|---|
| Perpetual trust: | | |
| Fair value at beginning of the year | $ 15,258 | 14,299 |
| Net realized and change in unrealized gains | 1,177 | 1,653 |
| Appropriation of endowment assets for expenditure | (739) | (694) |
| Fair value at end of the year | $ 15,696 | 15,258 |

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

## (7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Land and land improvements (5–25 yrs) | $ | 7,911 | 7,328 |
| Buildings and building improvements (10–40 yrs) | | 67,094 | 67,017 |
| Equipment (3–25 yrs) | | 122,662 | 114,099 |
| Projects in process | | 395 | 1,217 |
| | | 198,062 | 189,661 |
| Less accumulated depreciation and amortization | | (135,691) | (125,787) |
| Property and equipment, net | $ | 62,371 | 63,874 |

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

## (8) Long-Term Obligations

In May 1997 the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds (Bonds) payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments | $ | 19,625 | 21,475 |
| Capital leases | | 891 | 1,531 |
| | | 20,516 | 23,006 |
| Less unamortized portion of bond discount | | (116) | (142) |
| Less current portion | | (2,509) | (2,490) |
| | $ | 17,891 | 20,374 |

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

| | | Long-term obligations | Capital leases |
|---|---|---|---|
| Year ending September 30: | | | |
| 2015 | $ | 1,960 | 549 |
| 2016 | | 2,090 | 248 |
| 2017 | | 2,215 | 94 |
| 2018 | | 2,360 | — |
| 2019 | | 2,510 | — |
| Thereafter | | 8,490 | — |
| | $ | 19,625 | 891 |
| Interest payments | | | 153 |
| | | | $ 1,044 |

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,000 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

## (9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.

## (10) Unrestricted, Temporarily, and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

| | Total | Controlling interest | Noncontrolling interest |
|---|---|---|---|
| Unrestricted net assets, beginning of year | $ 32,634 | 32,332 | 302 |
| Excess (deficiency) of revenues over expenses | 12,846 | 12,414 | 432 |
| Net assets released from restriction for capital expenditures | (48) | (48) | — |
| Transfers to affiliates | (363) | 1 | (364) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | (527) | (527) | — |
| Change in accumulated pension charges to unrestricted net assets | (13,377) | (13,377) | — |
| Unrestricted net assets, end of year | $ 31,165 | 30,795 | 370 |

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

| | Total | Controlling interest | Noncontrolling interest |
|---|---|---|---|
| Unrestricted net assets, beginning of year | $ 880 | 528 | 352 |
| Excess (deficiency) of revenues over expenses | 10,508 | 10,153 | 355 |
| Net assets released from restriction for capital expenditures | 545 | 545 | — |
| Transfers to affiliates | (519) | (114) | (405) |
| Change in unrealized gains on marketable securities and other assets whose use is limited | 401 | 401 | — |
| Change in accumulated pension charges to unrestricted net assets | 20,819 | 20,819 | — |
| Unrestricted net assets, end of year | $ 32,634 | 32,332 | 302 |



(Continued)

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Cancer | $ | 212 | 196 |
| Building and equipment | | 421 | 428 |
| Community services | | 511 | 518 |
| Education | | 186 | 153 |
| Other | | 1,085 | 974 |
| | $ | 2,415 | 2,269 |

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations | $ | 15,713 | 15,287 |
| Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support: | | | |
| Hospital operations | | 818 | 818 |
| Medical education | | 150 | 150 |
| | $ | 16,681 | 16,255 |

## (11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The Hospital's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the Hospital has no funds designated by the Board of Directors as endowment.

The Hospital has interpreted 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. 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 (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment 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 of prudence prescribed by the Act.

The Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the Hospital and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the Hospital, and the investment policies of the Hospital.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Donor-restricted endowment funds at September 30, 2014 | $ | 457 | 16,681 | 17,138 |
| Donor-restricted endowment funds at September 30, 2013 | $ | 375 | 16,255 | 16,630 |

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Endowment net assets, September 30, 2013 | $ | 375 | 16,255 | 16,630 |
| Investment return: | | | | |
| Investment income | | 110 | 913 | 1,023 |
| Net (depreciation) appreciation | | (23) | 264 | 241 |
| Total investment return | | 87 | 1,177 | 1,264 |
| Appropriation of endowment assets for expenditure | | (5) | (751) | (756) |
| Endowment net assets, September 30, 2014 | $ | 457 | 16,681 | 17,138 |

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Endowment net assets, September 30, 2012 | $ | 261 | 15,306 | 15,567 |
| Investment return: | | | | |
| Investment income | | 96 | 789 | 885 |
| Net appreciation | | 19 | 864 | 883 |
| Total investment return | | 115 | 1,653 | 1,768 |
| Appropriation of endowment assets for expenditure | | (1) | (704) | (705) |
| Endowment net assets, September 30, 2013 | $ | 375 | 16,255 | 16,630 |

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the Hospital's control as to spending and investment policies.

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 emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The Hospital follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the Hospital expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

## (12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and are subject to change. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Reserves for premiums held on deposit at beginning of year | $ | 10,544 | 6,657 |
| Current period payments from loss escrow | | 4,600 | 2,450 |
| Change in reserve for premiums held on deposit for loss portfolio transfer | | 374 | 6,673 |
| Current period payments from reserves for premiums held on deposit | | 403 | 5,236 |
| Reserves for premiums held on deposit at end of year | $ | 15,115 | 10,544 |

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Balance at beginning of period | $ | 14,993 | 14,750 |
| Less reinsurance recoverable | | (2,650) | (2,300) |
| Net balance at beginning of period | | 12,343 | 12,450 |
| Incurred related to: | | | |
| Current year | | 4,547 | 4,493 |
| Prior years | | (993) | (4,034) |
| Total incurred | | 3,554 | 459 |
| Paid related to: | | | |
| Current year | | 73 | 3 |
| Prior years | | 350 | 563 |
| Total paid | | 423 | 566 |
| Net balance at end of period | | 15,474 | 12,343 |
| Add reinsurance recoverable | | 2,750 | 2,650 |
| Balance at end of period | $ | 18,224 | 14,993 |

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

## (13) Retirement Plans

### *(a) Defined Benefit Plan*

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Change in benefit obligation: | | | |
| Benefit obligation, beginning of year | $ | 124,196 | 138,482 |
| Interest cost | | 6,064 | 5,613 |
| Actuarial loss (gain) | | 17,454 | (13,726) |
| Benefits paid | | (6,786) | (6,173) |
| Benefit obligation, end of year | | 140,928 | 124,196 |
| Change in plan assets: | | | |
| Fair value of plan assets, beginning of year | | 66,215 | 59,683 |
| Actual return on plan assets | | 6,091 | 7,340 |
| Contributions | | 4,121 | 5,365 |
| Benefits paid | | (6,786) | (6,173) |
| Fair value of plan assets, end of year | | 69,641 | 66,215 |
| Funded status at year end | $ | (71,287) | (57,981) |
| Amounts recognized in consolidated balance sheets consist of: | | | |
| Noncurrent liabilities | $ | (71,287) | (57,981) |
| Accumulated charges to unrestricted net assets, consisting of net actuarial losses | | 56,338 | 42,961 |
| Net amount recognized | $ | (14,949) | (15,020) |

The prior service cost that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Components of net periodic benefit cost: | | | |
| Interest cost | $ | 6,064 | 5,613 |
| Expected return on plan assets | | (5,064) | (4,724) |
| Net amortization and deferral | | 3,050 | 4,477 |
| Net periodic benefit cost | | 4,050 | 5,366 |
| Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands): | | | |
| Net (loss) gain | | (10,327) | 25,296 |
| Net amortization and deferral | | (3,050) | (4,477) |
| (Decrease) increase recognized in changes to unrestricted net assets | | (13,377) | 20,819 |
| (Decrease) increase to unrestricted net assets associated with recognized net periodic benefit cost and (charge) credit to accumulated pension charge | $ | (17,427) | 15,453 |

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

| | 2014 | 2013 |
|---|---|---|
| Weighted average assumptions at September 30: | | |
| Discount rate for benefit obligations | 4.55% | 5.02% |
| Discount rate for net periodic benefit cost | 5.02 | 4.15 |
| Expected return on plan assets | 8.00 | 8.00 |

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

| | | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|---|
| Money market funds | $ | 2,241 | — | — | 2,241 |
| Domestic corporate bonds | | — | 12,827 | — | 12,827 |
| U.S. government and agency obligations | | — | 261 | — | 261 |
| Equity mutual funds | | 47,991 | — | — | 47,991 |
| Fixed income mutual funds | | 6,321 | — | — | 6,321 |
| Preferred equity securities | | — | — | — | — |
| Total | $ | 56,553 | 13,088 | — | 69,641 |

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

| | | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|---|
| Money market funds | $ | 1,745 | — | — | 1,745 |
| Domestic corporate bonds | | — | 14,443 | — | 14,443 |
| U.S. government and agency obligations | | — | 291 | — | 291 |
| Equity mutual funds | | 44,545 | — | — | 44,545 |
| Fixed income mutual funds | | 4,747 | — | — | 4,747 |
| Preferred equity securities | | — | 444 | — | 444 |
| Total | $ | 51,037 | 15,178 | — | 66,215 |

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

The following benefit payments are expected to be paid (in thousands):

| | | |
|---|---|---|
| 2015 | $ | 7,408 |
| 2016 | | 7,574 |
| 2017 | | 7,848 |
| 2018 | | 8,196 |
| 2019 | | 8,422 |
| 2020 through 2024 | | 45,151 |
| | $ | 84,599 |

***(b) Defined Contribution Plan***

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

***(c) Supplemental Pension Plan***

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

## (14) Leases and Rental Expenses

Rental expense aggregated approximately $6,303,000 and $6,138,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

| | | |
|---|---|---|
| Fiscal year: | | |
| 2015 | $ | 3,208 |
| 2016 | | 2,429 |
| 2017 | | 1,654 |
| 2018 | | 1,349 |
| 2019 | | 1,186 |
| 2020 and thereafter | | 5,253 |
| | $ | 15,079 |

The Hospital rents space from SMHS in a medical office building for approximately $13,000 per month.

## (15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried using the equity method, and the carrying value is approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

## (16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

## (17) Investments in Joint Venture Arrangements

### *Naugatuck Valley MRI Limited Partnership*

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

## (18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Investment income related to short-term investments and investments for self-insurance | $ | 280 | 276 |
| Cafeteria | | 1,170 | 1,173 |
| Outside services | | 545 | 274 |
| State grants | | 656 | 742 |
| Parking fees | | 232 | 320 |
| Day care | | 718 | 665 |
| Rentals | | 1,242 | 1,263 |
| Meaningful use | | 2,962 | 1,149 |
| Other | | 1,971 | 1,009 |
| Total | $ | 9,776 | 6,871 |

## (19) Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Health care services | $ | 225,237 | 215,207 |
| General and administrative | | 43,745 | 39,372 |
| | $ | 268,982 | 254,579 |

## (20) Activities Between Affiliates

During 2014 and 2013, the Foundation distributed $80,000 and $311,000, respectively, to the Hospital to support programs and services.

In addition to the lease activity with affiliates described in note 14, all employees of SMHS and the Foundation are paid through the Hospital's payroll system, and the amounts paid are charged directly to the related affiliate. In addition, time spent by certain Hospital employees on affiliate activities is charged to the related affiliate.

## (21) Subsequent Events

The Hospital has evaluated events through December 22, 2014, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the Hospital's consolidated financial statements except as disclosed below.

Exhibit 1

**SAINT MARY'S HOSPITAL, INC.**

Consolidating Balance Sheet

September 30, 2014

(In thousands)

| | Saint Mary's Hospital | Franklin Medical Group, P.C. | Saint Mary's Indemnity Company, LLC | Southbury Diagnostic Imaging Center, Inc. | Eliminations | 2014 Consolidated |
|---|---|---|---|---|---|---|
| Current assets: | | | | | | |
| Cash and cash equivalents | $ 24,610 | 823 | — | 364 | — | 25,797 |
| Short-term investments | 17 | — | — | — | — | 17 |
| Current portion of assets whose use is limited | 1,145 | — | 4,803 | — | — | 5,948 |
| Accounts receivable, net | 26,816 | 2,999 | (68) | 381 | 68 | 30,196 |
| Other current assets | 6,108 | 253 | 5,749 | 17 | (5,515) | 6,612 |
| Total current assets | 58,696 | 4,075 | 10,484 | 762 | (5,447) | 68,570 |
| Marketable securities | 20,803 | — | — | — | — | 20,803 |
| Assets whose use is limited: | | | | | | |
| By donor and held in trust by others | 15,696 | — | — | — | — | 15,696 |
| For estimated self-insurance liability | — | — | 41,038 | — | — | 41,038 |
| By bond indenture | 4,321 | — | — | — | — | 4,321 |
| Net interest in Foundation | 5,182 | — | — | — | — | 5,182 |
| Other | 6 | — | — | — | — | 6 |
| Total assets whose use is limited | 25,205 | — | 41,038 | — | — | 66,243 |
| Less current portion of assets whose use is limited | 1,145 | — | 4,803 | — | — | 5,948 |
| Noncurrent assets whose use is limited | 24,060 | — | 36,235 | — | — | 60,295 |
| Property and equipment, net | 59,768 | 1,417 | — | 1,186 | — | 62,371 |
| Other assets: | | | | | | |
| Investments in joint venture arrangements | 23,723 | — | — | — | (13,699) | 10,024 |
| Deferred financing costs, net | 103 | — | — | — | — | 103 |
| Total other assets | 23,826 | — | — | — | (13,699) | 10,127 |
| Total assets | $ 187,153 | 5,492 | 46,719 | 1,948 | (19,146) | 222,166 |



(Continued)

Exhibit 1

**SAINT MARY'S HOSPITAL, INC.**

Consolidating Balance Sheet

September 30, 2014

(In thousands)

| | Saint Mary's Hospital | Franklin Medical Group, P.C. | Saint Mary's Indemnity Company, LLC | Southbury Diagnostic Imaging Center, Inc. | Eliminations | 2014 Consolidated |
|---|---|---|---|---|---|---|
| Current liabilities: | | | | | | |
| Current portion of long-term obligations | $ 2,101 | — | — | 408 | — | 2,509 |
| Accounts payable | 16,795 | 432 | — | 25 | — | 17,252 |
| Salaries, wages, and payroll withholdings | 3,974 | 1,370 | — | 299 | — | 5,643 |
| Due to third-party payors, net | 783 | — | — | — | — | 783 |
| Accrued expenses and other current liabilities | 13,994 | 504 | 5,038 | 219 | (5,447) | 14,308 |
| Total current liabilities | 37,647 | 2,306 | 5,038 | 951 | (5,447) | 40,495 |
| Long-term liabilities: | | | | | | |
| Long-term obligations, net of current portion | 17,818 | — | — | 73 | — | 17,891 |
| Estimated self-insurance liability | 3,278 | — | 28,536 | — | — | 31,814 |
| Pension and deferred compensation | 72,182 | — | — | — | — | 72,182 |
| Other long-term liabilities | 9,464 | 59 | — | — | — | 9,523 |
| Total long-term liabilities | 102,742 | 59 | 28,536 | 73 | — | 131,410 |
| Net assets (deficit): | | | | | | |
| Unrestricted | 27,668 | 3,127 | 13,145 | 924 | (14,069) | 30,795 |
| Noncontrolling interest in subsidiaries | — | — | — | — | 370 | 370 |
| Total unrestricted | 27,668 | 3,127 | 13,145 | 924 | (13,699) | 31,165 |
| Temporarily restricted | 2,415 | — | — | — | — | 2,415 |
| Permanently restricted | 16,681 | — | — | — | — | 16,681 |
| Total net assets | 46,764 | 3,127 | 13,145 | 924 | (13,699) | 50,261 |
| Total liabilities and net assets | $ 187,153 | 5,492 | 46,719 | 1,948 | (19,146) | 222,166 |

See accompanying independent auditors' report.

Exhibit 2

**SAINT MARY'S HOSPITAL, INC.**

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

| | Saint Mary's Hospital | Franklin Medical Group, P.C. | Saint Mary's Indemnity Company, LLC | Southbury Diagnostic Diagnostic Imaging Center, Inc. | Eliminations | 2014 Consolidated |
|---|---|---|---|---|---|---|
| Revenues: | | | | | | |
| Revenue from patient services, net of contractual allowances | $ 248,807 | 24,157 | — | 6,197 | — | 279,161 |
| Provision for uncollectible accounts | (10,078) | (996) | — | — | — | (11,074) |
| Net revenue from patient services | 238,729 | 23,161 | — | 6,197 | — | 268,087 |
| Other operating revenues | 8,706 | 4,039 | 5,070 | 16 | (8,055) | 9,776 |
| Total revenues | 247,435 | 27,200 | 5,070 | 6,213 | (8,055) | 277,863 |
| Expenses: | | | | | | |
| Salaries and wages | 85,350 | 26,689 | — | 1,168 | — | 113,207 |
| Employee benefits | 24,562 | 3,778 | — | 280 | — | 28,620 |
| Supplies and other expenses | 106,022 | 9,260 | 4,092 | 3,370 | (7,482) | 115,262 |
| Depreciation and amortization | 9,888 | 283 | — | 284 | — | 10,455 |
| Interest | 1,405 | — | — | 33 | — | 1,438 |
| Total expenses | 227,227 | 40,010 | 4,092 | 5,135 | (7,482) | 268,982 |
| Operating income (loss) | 20,208 | (12,810) | 978 | 1,078 | (573) | 8,881 |
| Nonoperating gains (losses): | | | | | | |
| Investment income, net | 2,279 | — | 1,545 | — | — | 3,824 |
| Equity in earnings of joint ventures | 3,359 | — | — | — | (3,170) | 189 |
| Change in net assets of Foundation | 281 | — | — | — | — | 281 |
| Net loss on disposal of assets | (46) | — | — | — | — | (46) |
| Other | (856) | — | — | — | 573 | (283) |
| Total nonoperating gains (losses), net | 5,017 | — | 1,545 | — | (2,597) | 3,965 |
| Excess (deficiency) of revenues over expenses | 25,225 | (12,810) | 2,523 | 1,078 | (3,170) | 12,846 |
| Net assets released from restriction | (48) | — | — | — | — | (48) |
| Capital transactions, net | (14,778) | 14,778 | — | (910) | 547 | (363) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | (527) | — | (486) | — | 486 | (527) |
| Change in accumulated pension charges to unrestricted net assets | (13,377) | — | — | — | — | (13,377) |
| (Decrease) increase in unrestricted net assets | $ (3,505) | 1,968 | 2,037 | 168 | (2,137) | (1,469) |

See accompanying independent auditors' report.

# EXHIBIT 23

Internal Revenue Service

Date: JAN 15 2009

SAINT MARYS HOSPITAL INC
56 FRANKLIN ST
WATERBURY CT 06706-1253

Department of the Treasury
P. O. Box 2508
Cincinnati, OH 45201

**Person to Contact:**
Michelle Jones
ID# 0203153
**Toll Free Telephone Number:**
877-829-5500
**Federal Identification Number:**
06-0646844
**Group Exemption Number:**
0928

Dear Sir or Madam:

This is in response to your request of November 14, 2008, regarding your tax-exempt status.

Our records indicate that you are recognized as exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. You are included in the group ruling issued to the United States Conference of Catholic Bishops, which is not a private foundation within the meaning of 509(a) of the Code because it is described in section 509(a)(1) and 170(b)(1)(A)(i).

The United States Conference of Catholic Bishops is listed in Publication 78.. Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to them or for their use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Since you are included in a group ruling, there is no individual exemption letter. The group exemption letter applies to all of the subordinate organizations on whose behalf the United States Conference of Catholic Bishops has applied for recognition of exemption. If you want a copy of the group exemption letter, please contact your central organization.

If you are operating an educational organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, you are required to file Form 5578, *Annual Certification of Racial Nondiscrimination for a Private School Exempt From Federal Income Tax*. Form 5578 is due annually by the 15th day of the 5th month following the end of the organization's accounting period.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

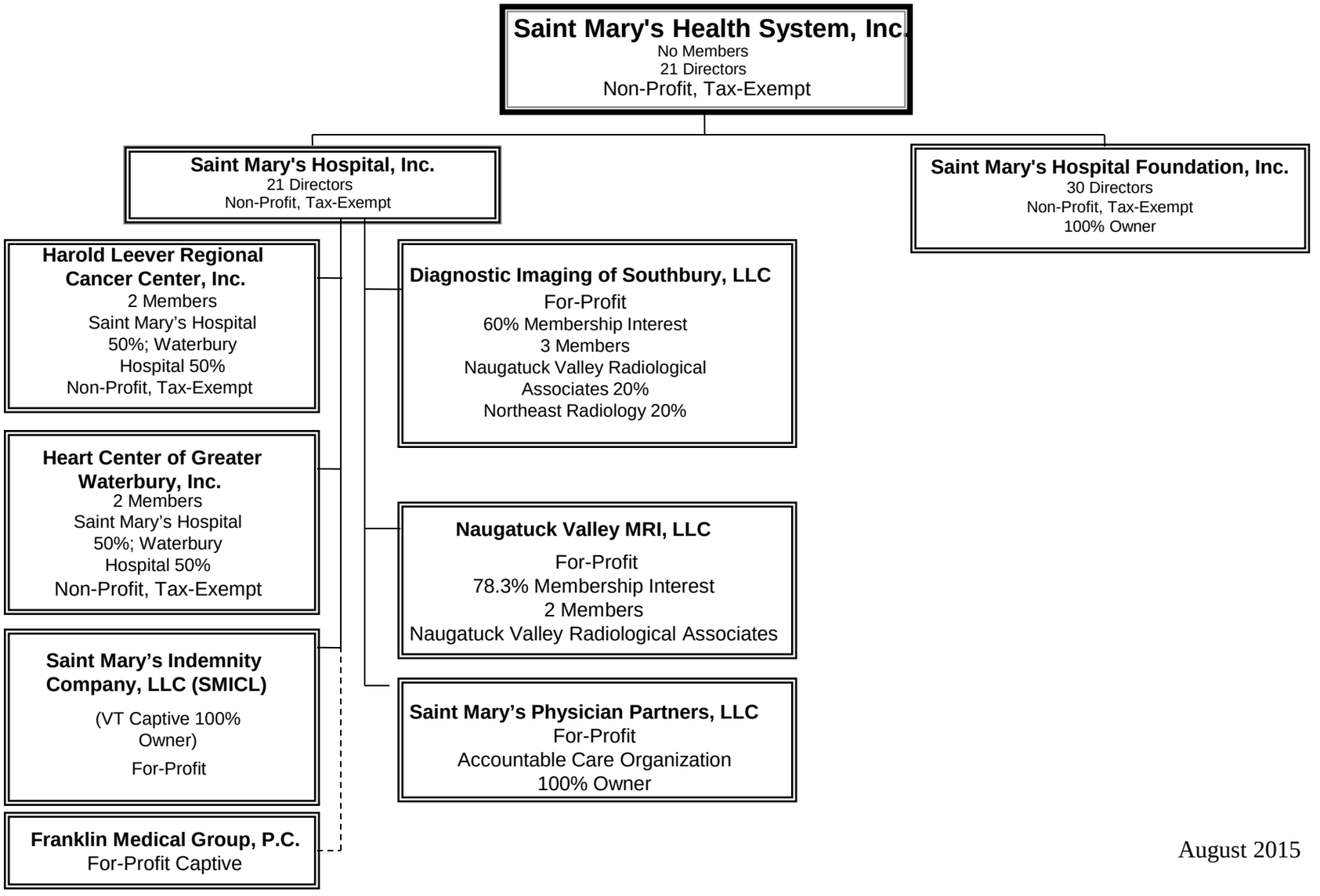
Sincerely,

Cindy Westcott

Cindy Westcott,
Manager, Exempt Organizations
Determinations

# EXHIBIT S1

# Corporate Structure




August 2015

# EXHIBIT S2

# Saint Mary's Hospital

## CHNA IMPLEMENTATION STRATEGY

## BACKGROUND

Saint Mary's Hospital has served the city of Waterbury since 1907, when it was founded by the Sisters of Saint Joseph of Chambery. The founding of the hospital was made possible by a generous donation by the Right Reverend Monsignor William J. Slocum. In its first year, Saint Mary's Hospital was a 120 bed facility and had a staff of 14. It is now licensed for 347 beds and employs more than 1,800 people. The mission of Saint Mary's Hospital is to provide excellent healthcare in a spiritually enriched environment to improve the health of our community. The vision of Saint Mary's Hospital is to be the leading regional healthcare provider. Saint Mary's Hospital values are:

- Integrity: Commitment to doing what is right
- Caring: Compassionate approach to addressing the healthcare needs of all people
- Accountability: Personal responsibility for the performance of Saint Mary's Health System
- Respect: Respect for the dignity, worth, and rights of others
- Excellence: Working together in pursuit of superior clinical quality and service to others

Saint Mary's Hospital serves the city of Waterbury and 17 surrounding towns. In 2013, Saint Mary's 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 Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Saint Mary's 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 Saint Mary'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.

## THE CHNA PROCESS

Saint Mary's Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. 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 Community Needs
6. Implementation Strategy

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Waterbury Department of Public Health, Connecticut Department of Health, and Centers for Disease Control and Prevention, among others. The report depicts 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 (BRFSS) 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 Saint Mary's Hospital in addressing the identified barriers.

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 Community Health Needs Assessment (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.

Saint Mary's Hospital developed an **Implementation Strategy** to outline what community health needs it plans to address, as well as specific goals and measures to evaluate community health improvement initiatives.

## 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 by partners of the the Greater Waterbury Health Improvement Partnership, including Saint Mary's Hospital. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives of the session were:

- To review recently compiled community health data and highlight key research findings;
- To gather feedback from community representatives about community health needs;
- To prioritize the community health needs based on select criteria.

### Prioritization Process

Holleran Consulting facilitated the prioritization session. The meeting began with an abbreviated research overview, including 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 asked to share openly what they perceived to be the needs and areas of opportunity in the community. Through facilitated discussion, attendees developed the following "Master List" of potential priority areas.

Master list of community priorities (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

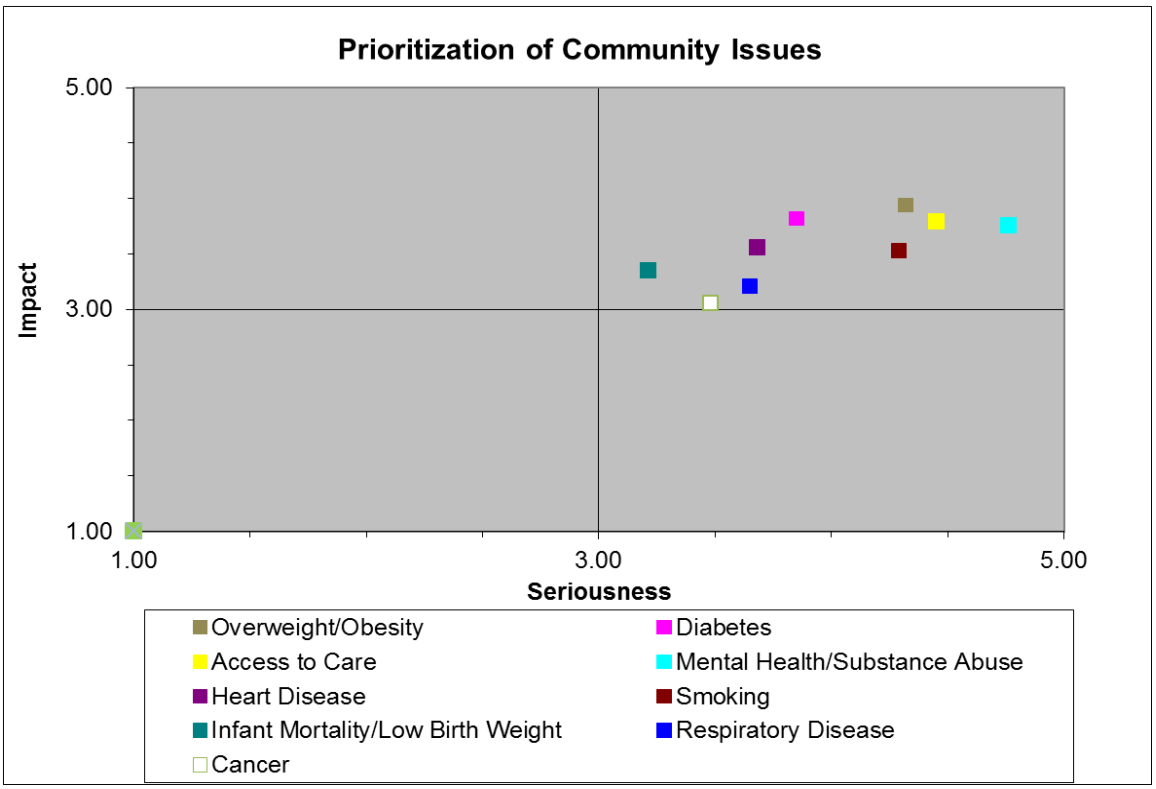
Once the Master List was compiled, participants were asked to rate each need based on two criteria. The two criteria included the "seriousness of the issue" and the "community's ability to impact the issue." Respondents were asked to rate each issue on a scale of 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact). 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 (4.76), followed by Access to Care (4.45), and Overweight and Obesity (4.32). The ability to impact Overweight and Obesity was rated the highest (3.94), followed by Diabetes (3.82), and Access to Care (3.79).

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
- Chronic Disease (Obesity, Diabetes, Heart Disease and Asthma)
- Smoking

## STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Saint Mary's Hospital developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, objectives and initiatives, and inventory of existing community assets and resources for each of the four priority areas are listed below.

### I. Access to Care

**Goal:** Improve access to comprehensive, culturally competent, quality health services.

**Objectives:**

- Increase the proportion of patients with health insurance
- Increase the proportion of persons who have a specific source of ongoing care

**Key Indicators:**

- Number of uninsured patients approved for health insurance programs
- Number of patients who report having a primary care provider
- Number of patients participating in the Children & Youth Medical Home Initiative

**Existing Programs**

*Hospital-Based Access to Care Programs*

- Saint Mary's has patient financial advocates who help patients qualify for insurance programs such as Medicaid. In 2012, these advocates assisted 656 individuals in obtaining insurance coverage.

*Grant-Funded*

- Saint Mary's has received grant funding from the Connecticut Department of Public Health for the Children and Youth with Special Health Care Needs Medical Home. This Medical Home develops care plans and provides healthcare for children and youth with chronic physical and/or behavioral issues.
- Saint Mary's has grant funding from the Connecticut Department of Public Health for the Connecticut Cancer and Heart Disease Integrated Health Screening program (CHDIHS), which was formerly known as the Breast and Cervical Grant. This program provides screening for breast and cervical cancer and if a cancer is diagnosed through the grant, funds are available for treatment. CHDIHS recently integrated a colorectal screening component.
- Saint Mary's Children's and Family Health Center, Dental Clinic and Outpatient Behavioral Health Center provide services to patients who are uninsured, under-insured or have

Medicaid. Thousands of patients receive services through these clinics; these clinics have over 50,000 visits per year.

**Initiatives**

- Collaborate with the Connecticut Health Insurance Exchange to help residents gain access to health insurance.
- Evaluate opportunities to improve access to primary and urgent care.
- Enhance cost estimate and insurance verification programs so patients can better understand financial responsibilities in advance.
- Provide appropriate technology in hospital to enhance patient experience across multiple settings.
- Educate health care providers on resources (e.g., Malta House of Care) for uninsured/underinsured and low income patients and families.
- Develop nurse navigator programs where appropriate to improve access to primary care and behavioral health.

**Existing Community Resources**

Chase Family Resource Center
Community Health Centers, Inc.
Malta House of Care
New Opportunities, Inc.
StayWell Health Center, Inc.
Waterbury Health Access Program
Waterbury Department of Public Health

## II. 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 number of points of access for referral to services

**Key Indicators**

- Number and percent of patients in the Emergency Department whose primary diagnosis is related to mental / behavioral health.
- Length of stay in ED for mental / behavioral health patients.
- Number of ED referrals for mental / behavioral health care services.

**Existing Programs**

- Saint Mary's has a twelve-bed inpatient psychiatric unit. In FY 12, 611 patients were discharged from the unit. The average length of stay in the unit is 6.36 days.
- Saint Mary's has an intensive outpatient behavioral health program. Approximately, 1,800 patients receive services through this program each year.
- Saint Mary's Emergency Department is a resource for patients with behavioral health needs. In 2012, 11,163 ED patients had a primary diagnosis related to behavioral health. These patients represent 16% of total visits (70,067). The average length of stay for behavioral health patients in the ED was 38.4 hours or 1.6 days. Some of the ED behavioral health patients receive services in the seven-bed behavioral health holding unit.

**Initiatives**

- Evaluate options to enhance Behavioral Health unit in the Emergency Department to better meet patient needs.
- Analyze potential for development of a Community Crisis Center or Behavioral Health Walk In Center.
- Evaluate options to develop a Geriatric Emergency Department Program to reduce unnecessary ED utilization.
- Continue to participate in the Connecticut Behavioral Health Partnership, which is organized through ValueOptions.
- Evaluate Community Care Team program based at Middlesex Hospital and determine if a similar model could work in Waterbury.
- Evaluate potential for an ambulatory detoxification program.

**Resources**

Catholic Family Services
Community Health Centers, Inc.
Family Services of Greater Waterbury
Home to Home Foundation
Neighborhood Housing Services of Waterbury
StayWell Health Center, Inc.
Visiting Nurses Association
Waterbury Department of Public Health
Waterbury Youth Services
Wellmore Behavioral Health

## III. Chronic Diseases (Obesity, Heart Disease, Diabetes, and Asthma)

**Goal:** Promote health and reduce chronic disease through healthy 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
- Reduce risk factors for chronic disease

**Indicators:**

- Number and percent of patients who are obese or overweight at the time of their visit.
- Number and percent of patients receiving inpatient and outpatient nutritional counseling.
- Number of children in the Early Obesity Prevention Program that demonstrate improved weight.
- Number of children who receive meals through the Health Nutrition Grant.
- Number of physicians participating in the Easy Breathing Program.
- Number and percent of hospital meals that meet Sodexo's Mindful Meal Selection Program.
- Number and percent of residents utilizing the farmer's market who report increased consumption of fruits and vegetables.
- Number of food prescriptions written.

**Existing Programs**

*Obesity and Heart Disease*

- Saint Mary's offers inpatient and outpatient nutritional counseling.
- Saint Mary's has a bariatric program. Services offered through the program include monthly educational seminars, nutritional counseling, gastric bypass and gastric banding surgery, and support groups. In FY 2012, 112 patients had obesity surgery.
- Saint Mary's works with community organizations on the Early Childhood Obesity Prevention Program. This program is funded by Saint Mary's Hospital, the Connecticut Community Foundation and the American Heart Association. The grant is in its first phase to collect local data on childhood obesity. The second phase will include developing interventions to reduce obesity.
- Saint Mary's Children's Development Center has a Bureau of Health Nutrition Grant to provide lunch and snacks for children who live in poverty. This grant is partially funded by the Department of Education.
- Food services at Saint Mary's are provided by Sodexo. Sodexo offers a Mindful Meal Program that includes low calorie and low fat healthy food options.

*Asthma and Diabetes*

- The Easy Breathing program works to inform physician practices and foster a community-based approach to pediatric asthma and review program data at the community level.
- The Connecticut Community Foundation and the American Hospital Association has awarded Saint Mary's a grant for diabetes education in the Naugatuck area. This is collaboration with the Heart Center of Greater Waterbury.

**Initiatives**

- Collaborate with Brass City Harvest to offer a farmer's market.
- Evaluate ways to continue to improve meal choices at the hospital.
- Support the Waterbury Department of Public Health's food and nutrition programs (such as the Healthy Corner Stores Initiative Food Prescription Programs).
- Participate in the American Heart Association Mission Lifeline Program.
- Determine possibility of holding community education and screening events in collaboration with local providers.
- Provide nurse educator to patients with Congestive Heart Failure to coordinate post-acute care services and provide patient and family education.

**Resources**

- Brass City Harvest
- Bridge to Success Community Partnership
- Community Health Centers, Inc.
- End Hunger Connecticut
- Heart Center of Greater Waterbury
- New Opportunities, Inc.
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

## IV. 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

**Key Indicators**

- Number of people participating in smoking cessation programs and percent that successfully quit smoking.
- Number of patients who receive smoking cessation counseling.

**Existing Programs**

- The American Lung Association has awarded Saint Mary's tobacco cessation funds. Funds are currently available to cessation classes.
- All patients who are discharged from Saint Mary's Hospital receive Smoking Cessation educational materials in their discharge packets.

**Initiatives**

- Work with Harold Leever Regional Cancer Center to enhance smoking cessation program.
- Evaluate opportunities to pilot incentive program to increase smoking cessation rates.

**Resources**

- Community Health Centers, Inc.
- Harold Leever Regional Cancer Center
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

## RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Saint Mary's 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 Saint Mary's Hospital Board of Directors met on September 12, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the Implementation Strategy and provide the necessary resources and support to carry out the initiatives therein.

## Appendix E: Prioritization Session Participants – June 18, 2013

| 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 |

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|---|---|---|
| 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 S3

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 070016 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/29/14 |
|---|---|---|---|
| NAME OF FACILITY SAINT MARY'S HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 56 FRANKLIN ST, WATERBURY, CT 06706 | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| A000 | INITIAL COMMENTS<br><br>An authorized substantial allegation survey was concluded on October 29, 2014 in response to complaint #CT 17479 at:<br>Saint Mary's Hospital<br>56 Franklin St.<br>Waterbury, CT 06706<br><br>The following Conditions of Participation were reviewed as they pertain to the complaint:<br><br>Physical Environment 482.41<br>Infection Control 482.42<br>Governing Body 482.12<br>QAPI 482.21<br>Pharmaceutical Services 482.25 | A000 | | |
| A083 | 482.12(e) CONTRACTED SERVICES<br>The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions for the contracted service. | A083 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) 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 reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| A083 | This STANDARD is not met as evidenced by:<br>Based on observation, a review of facility documentation, and staff interviews the facilities governing body failed to ensure the hospitals quality program assessed services provided by an outside environmental monitoring company to identify quality and performance issues. The finding includes:<br><br>During a tour of the pharmacy on 10/15/14 at 10:00AM, a review of the facility environmental monitoring reports from January 2014 – October 2014 were conducted. It was noted that an independent company had conducted monthly testing of the compounding area of the pharmacy to determine if microbial contamination was present. The monthly reports identified site samples, total number of colonies, with genus identification in multiple locations with both surface and air sample. Interview with the Director of the Pharmacy on 10/15/14 at 10:00 AM indicated he spoke with the microbiologist from the company and was told that the findings did not require an action with the one exception of the floor sampling. The recommendation was to place a "tacky" mat on the floor entrance to the clean room in September of 2014 where compounding occurred, as most of the genus identified was located in this area. Further interview with the Director of the | A083 | Applies to tag A083<br>Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings.<br><br>Monitoring:<br>Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board.<br><br>Responsible Person:<br>Director of Pharmacy_ | October 30, 2014<br><br>Indefinite |

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| A083 | Pharmacy indicated he did not discuss the results of the monthly testing with the quality committee to determine the severity of the problem, interventions that may have been needed and/or opportunities for improvement to effectively deliver quality care and ensure patient safety. Interview with the Vice President of Nursing on 10/29/14 at 1:30 PM identified the governing body was not made aware of the environmental testing that was conducted in the pharmacy to ensure monitoring, improvement activities, and sustainability of quality problems. The hospital bylaws dated 12/20/07 directed in part, the quality coordinating council would monitor the performance improvement activities carried out within the hospital. Further review of the bylaws identified the governing body would be responsible to review infection control as it is related to the development of a mechanism for monitoring and reporting environmental condition with infection potential. | A083 | | |
| A273 | 482.21(a), (b)(1), (b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS<br><br>(a) Program Scope<br>(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve | A273 | | |

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| A273 | Health outcomes<br>(2) The hospital must measure, analyze, and track quality indicators and other aspects of performance that assess processes of care, hospital services and operations.<br>(b) Program data<br>(1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization.<br>(2) The hospital must use the data collected to--<br>(i) Monitor the effectiveness and safety of services and quality of care and<br>(3) The frequency and detail of data collection must be specified by the hospital's governing body.<br><br>This STANDARD is not met as evidence by:<br>Based on a review of the hospital documentation and interview with hospital personnel, the facility failed to assess and/or analyze environmental testing conducted in the pharmacy and/or failed to incorporate the hospital's quality improvement program to ensure patient safety and quality of care.<br>The finding includes:<br>. | A273 | | |

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| A273 | During a tour of the pharmacy on 10/15/14 at 10:00AM, a review of the facility environmental monitoring reports from January 2014 – October 2014 were conducted. It was noted that an independent company had conducted monthly testing of the compounding area of the pharmacy to determine if microbial contamination was present. The monthly reports identified site samples, total number of colonies, with genus identification in multiple locations with both surface and air sample. Interview with the Director of the Pharmacy on 10/15/14 at 10:00 AM indicated he spoke with the microbiologist from the company and was told that the findings did not require an action with the one exception of the floor sampling. The recommendation was to place a "tacky" mat on the floor entrance to the clean room in September of 2014 where compounding occurred, as most of the genus identified was located in this area. Further interview with the Director of the Pharmacy indicated he did not discuss the results of the monthly testing with the quality committee to determine the severity of the problem, interventions that may have been needed and/or opportunities for improvement to effectively deliver quality care and ensure patient safety. The hospital's performance improvement management plan directed in part, a performance improvement plan specific to the department's scope of care and to ensure the deployment of strategies based on measurement and assessment of process and outcomes. | A273 | Applies to tag A273<br><br>Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings.<br><br>Monitoring:<br>Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board.<br><br>Responsible Person:<br>Director of Pharmacy | |

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| | The chief executive officer, senior leadership and the executive leadership team would be responsible for assuring the identified key projects are reflected, measured and evaluated in the performance improvement plan with outcomes documented. | | | |
| A724 | 482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE<br><br>Facilities, supplies, equipment must be maintained to ensure an acceptable level of safety and quality.<br>This STANDARD is not met as evidenced by:<br>Based on review of facility documentation, review of facility policy, review of manufacturer's recommendations, observations and interviews, the facility failed to ensure that pharmacy equipment inspections and/or cleaning maintenance was conducted/documented as per manufacturer's recommendation, and/or facility policy and/or state law. The finding includes:<br><br>A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00 PM identified that the pharmacy had three glove compounding isolators. Isolator #3 had a maintenance sticker dated fir 9/2014 on the outer right side of the isolator. Review of isolator inspection documentation on 108/28/14 at 2:05PM indicated that all three isolators had HEPA | A724 | Applies to tag A724<br>Pharmacy Department and Facilities have both created an automated alert 3 weeks prior to the required inspection of the isolators as a reminder for follow up to Facilities contracted service for cleaning. In addition to contracted cleaning, twice monthly terminal cleaning has been scheduled with sporacidal disinfectant for the IV rooms.<br><br>Monitoring: Pharmacy Department will maintain an inspection log and this will be submitted to the Quality Department on an annual basis.<br><br>Responsible Person:<br>Director of Pharmacy | |

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| A724 | Filters and air velocity testing, by Company #2 on 1/20/13 and 7/8/13, testing was not conducted for January 2014. A change in vendor on 9/24/14 identified that Company #3 only tested isolators #2 and #3, and that isolator #1 was not tested. Interview with the Director of Pharmacy on 10/28/14 at 2:05 PM noted that there was a glitch in the testing schedule, Company #2 did not test the equipment in January 2014 as per contract and Company #3 was only capable of testing the positive pressure isolators, Isolator #2 and #3. The facility submitted a corrective action plan on 10/28/14 that included testing of the negative pressure isolator, Isolator 31, scheduled for 10/29/14. The facility IV Infection Control policy directed that, barrier isolators are inspected and certified every six months. | A724 | Applies to tag A749<br>Monthly Pharmacy environmental monitoring reports submitted to Quality Management/Infection Prevention Department monthly for review. Pharmacy Director or his designee reports to the Infection Prevention Committee quarterly to review findings.<br><br>Monitoring:<br>Infection Prevention minutes are regularly reviewed by Medical Executive Committee and the Quality and Patient Safety Committee of the Board. | |
| A749 | 482.42(a)(1) INFECTION CONTROL PROGRAM<br><br>The infection control officer or officers must develop a system for identifying documentation, review of facility policy, and interviews the facility failed to ensure that the infection control department was informed of positive mold cultures in the medication compounding area. The finding includes:<br>1. A tour of the pharmacy department was conducted on 10/27/14 at 2:00PM with the Director of Pharmacy. Observation on 10/27/14 at 2:00PM identified a door at the back of the department lead to a room that contained, in part, three isolators for medication compounding. Review of facility | A749 | Responsible Person:<br>Director of Pharmacy | October 30, 2014<br><br>Indefinite |

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| A749 | contracts and/or environmental monitoring reports on 10/27/14 indicated that Company #1 performed environmental culturing in the pharmacy department as per facility contract. The monitoring reports further noted that 1 to 3 mold spores were cultured on the surfaces and/or floor and/or in the air of the medication compounding room (not in the compounding isolators) in January, February, May, June, July, August, and September 2014. The monitoring reports further documented that the Director of Pharmacy did not take steps to remediate the presence of mold until June 2014 when cleaning processes were reviewed, and/or when dynamic testing was conducted in August 2014 and/or the institution of a "sticky mat" in September 2014. Review of Pharmacy and Therapeutics committee minutes from 1/2014 to 9/2014 lacked documentation of the mold spores and/or the steps taken by pharmacy to remediate the mold. Review of Infection Control (IC) meeting minutes from 1/2014 to 9/2014 lacked documentation of the pharmacy cultures and/or remediation. Interview with the Director of Pharmacy on 10/27/14 at 2:30PM identified that although the pharmacy mold levels were far below actionable levels, he consulted with the contracted microbiologist for ideas to eliminate/decrease the mold. | A749 | | |

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| A749 | Review of IC meeting minutes and further interview with the Director of Pharmacy on 10/27/14noted that the IC team had never been made aware of an/or been involved in environmental culturing results/remediation's as the levels were non-actionable. Interview with the Infectious Disease Physician on 10/29/14 at 11:12Am indicated that, going forward, he/she would like to see a grid to reflect known unacceptable culture levels and the pharmacy culture results trends. The facility IC plan identified that the program was an institution-wide program whose main objectives are the prevention and control of infections. The IC plan included a major function to design and execute routine surveillance data collection and analysis activities and to develop review, and revise hospital-wide infection prevention policies and procedures. According to the USP 797, highly pathogenic microorganisms, to include mold, must be immediately remedied regardless of the colonizing forming unit count, with the assistance of a competent microbiologist, IC professional or industrial hygienist.<br>2. A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00PM identified that Pharmacy Technician #1 placed items in the antechamber of Isolator #3, sprayed the antechamber with sterile 70% Isopropyl alcohol and after donning | A749 | | |

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| A749 | the isolator's gloves/sleeves, moved the items form antechamber to the main chamber and began the medication compounding procedure.<br>Following the procedure, Pharmacy Technician #1 moved the items to the antechamber, removed his/her gloved hands from the isolator's gloves/sleeves and removed all items from the antechamber. Pharmacy cleaning logs identified that Glove Box A and Glove Box B (Isolators #2 and #3) were cleaned on each shift. The cleaning logs laced evidence of any additional cleaning of Isolators #1 and/or cleaning of the negative pressure isolator (Isolator #1). In addition documentation could not be provided for required isolator glove changes. Interview with the Director of Pharmacy on 10/27/14 at 2:30 PM indicated that isolator glove are changed daily and on the morning shift and that this was not documented. He further noted that additional cleaning of isolators was performed if soiling was noted in the chamber and was not performed between compounding – sterile preparations (CSP). Interview with the Performance Improvement Specialist on 10/28/14 at 8:55AM noted that the pharmacist would change gloves in Isolator #1 each day the isolator was used, which was approximately once a week and that this was not documented.<br>Manufacturer's recommendations for the IV isolators directed cleaning and disinfecting the isolator at the beginning of each shift and cleaning and sanitizing the isolator between CSP. | A749 | Applies to tag A749<br>The isolator daily logs have been updated to include isolation unit #1 and the frequency of changing of the isolator gloves.<br>The IV room IC policy was revised to change isolator glove changes from every other day to daily.<br><br>Monitoring: The isolator logs will be audited weekly for 6 weeks to ensure compliance.<br><br>Responsible Person:<br>Director of Pharmacy | November 3, 2014<br><br>December 15, 2014 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 070016 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/29/14 |
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| NAME OF FACILITY SAINT MARY'S HOSPITAL | STREET ADDRESS, CITY, STATE, ZIP CODE 56 FRANKLIN ST, WATERBURY, CT 06706 | | |

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| A749 | The IV room IC policy directed that barrier isolator gloves will be changed every other day.<br>3. A tour of the pharmacy department was conducted with the Director of Pharmacy on 10/27/14. Observation on 10/27/14 at 2:00PM identified that Pharmacy Technician #1 placed items on the antechamber of isolator #3, sprayed the antechamber with sterile 70% isopropyl alcohol and after donning the isolators gloves/sleeves and a 20 second lapse in time, moved the items from the antechamber to the main chamber. Interview with Pharmacy Technician #1 on 10/27/14 at 2:08PM noted that, after the antechamber and items therein were sprayed with the alcohol solution, items remained in the antechamber for as long to don the isolator gloves/sleeves, enter the main chamber and transfer the items. Interview with the Director of Pharmacy on 10/27/14 at 2:05PM noted that items needed to remain in the antechamber for 15-20 seconds after the isopropyl alcohol spray. Manufacturer's recommendations for the IV isolators directed that after cleaning and decontamination, the product is to remain in the transfer chamber (antechamber) receiving a sterile shower for a period of not less than 30 seconds prior to moving them to the main working chamber. | A749 | | |

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| A749 | 4. A tour of the pharmacy department was conducted on 10/27/14 at 2:00 PM with the Director of Pharmacy and identified that the facility had three isolators for medication compounding. Review of the annual pharmacy IV competency evaluations identified that all staff received the annual aseptic technique test and challenge kit competency testing in the fall of 2013. The facility IV Room IC policy, revised in 1/2014, directed that all pharmacy personnel must undergo performance evaluations (competencies) including gloved fingertip sampling and medial fill testing every 12 months. Interview with the Director of Pharmacy on 10/27/14 at 2:40PM noted that staff had not yet undergone gloved fingertip sampling as competencies are conducted in the fall. According too USP 797 (2012), all compounding personnel shall successfully complete an initial competency evaluation and gloved fingertips/thumb sampling no less than 3 times before initially being allowed to compound CSPs and re-evaluation shall occur at lease annually. | A749 | Applies to tag A749<br>All Pharmacy Compounding staff has completed glove fingertip competencies. To ensure annual compliance, glove fingertip competencies have been added to the annul Pharmacy IV Compounding competency.<br><br>Monitoring:<br>Quality Management to review Pharmacy competencies to ensure all staff has completed testing as scheduled annually.<br><br>Responsible Person:<br>Director of Pharmacy | November 30, 2014<br><br>December 12, 2014 |

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| A 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the Connecticut Department of Public Healtl1 during an authorized substantial allegation survey concluded on 914115 in response to complaint #18731 at:<br><br>St Mary's Hospital<br>54 Franklin St<br>Waterbury, CT 06706<br><br>The following Conditions of Participation were reviewed as they pertained to the complaint:<br><br>Governing Body 482.12<br>QAPI 482.21<br>Pharmaceutical Services 482.26<br><br>Condition level noncompliance was identified under:<br><br>Governing Body 482.12<br>Pharmaceutical Services 482.25<br><br>Acronyms and Abbreviations that may be used throughout this document include:<br><br>MD Medical Director<br>NM Nurse Manager<br>RN Registered Nurse<br>Pt Patient<br>Tx Treatment<br>QAPI Quality Assurance Program Improvement<br>P&P Policy and Procedure<br>EM Environmental Monitoring | A 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE {XQ)DATE

Any deficiency statement ending with an asterisk e) 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 instn1clions.) 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 disclosab!e 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 progran1 participation.

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| STATEMENT OF DEFICIENCIFS AND PIAN OF CORRECTION | (X1) PROVIOERJSIJPPUERJCLIA IDENTIFICATION NUMBER: | (X2} MULTIPLE CONSTRUCTION A. BUILDING B. WJNG | (X3) DATE SURVEY COMPLETED |
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| A 000 | Continued From page 1<br>Definitions:<br><br>USP-797: United States Pharmacopeia, Chapter 797, Requirements for licensed entities that compound sterile products.<br><br>BSC: Biological safety cabinet: an enclosed, ventilated lab workspace.<br><br>LAFW: Laminar flow workbench: where sterile preparations are combined under laminar air flow which is used to exclude contaminants.<br><br>PEC: Primary Engineering Controls: the environment in which sterile doses of hazardous drugs are compounded.<br><br>CACI: Compounding aseptic containment isolator, marked as "chemo hood", referenced in certification report.<br><br>CAI: Compounding aseptic isolator<br><br>PPE: Personal Protective Eq11lpment: gowns, hair covering, masks, gloves and booties that are worn by.personnel within the area of sterile compounding as directed by USP 797 standards.<br><br>CFU: Colony Forming Units: a measurement of how large a mold area has grown.<br><br>Certification of the rooms involve airborne non-viable particle counting (determining of ISO classification), airflow testing and smoke pattern est, room pressurization, HEPA filter leak test, general temperature and humidity.<br><br>Environmental Monitoring: is a combination of | A 000 | | |

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| A 000 | Continued From page 2<br>both the non-viable and viable testing done every 6 months. Non-viable is to determine the ISO classification. Viable testing includes surface and air sampling of the compounding areas including the hoods or PEC's (primary engineering controls).<br><br>USP 797 Environmental sampling: The ES program should provide information to staff and leadership to demonstrate that the PEG Is maintaining an environment within the compounding area that consistently ensures acceptably low viable and nonviable particle levels. Environmental Sampling data shall be collected and reviewed on a periodic basis as a means of evaluating the overall control of the compounding environment. | A 000 | | |
| A 043 | 482.12 GOVERNING BODY<br><br>The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.<br><br>This CONDITION Is not met as evidenced by: Based on observations, a review of hospital documentation, policies and interviews, it was determined that the hospital failed to meet the Condition of Participation for Governing Body. The findings included:<br><br>1. The Governing body did not ensure that services offered and provided met the Medicare Conditions of Participation. Areas of noncompliance identified include: Pharmaceutical | A 043 | | |

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| A 043 | Continued From page 3<br>Services. Refer to A·283, A-490, A-492, and A-501.<br><br>2. The Governing body failed to function effectively to ensure that culture testing was conducted In the off slte Intravenous (IV) Infusion Center by Company 111 (contracted service) prior to the initiation of compounding medications and/or failed to ensure that the contracted company provided quality services (Refer to A-83) and/or that mold/fungus growth that required the discontinuation of compounding was reported to the Governing body for review.<br><br>a. The infusion center was opened by the hospital on 9/4/14. Review of hospital documentation failed to provide evidence that culture testing was conducted in the isolator prior to the initiation of compounding. Review of the environmental reports and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 10:10 AM identified they were not aware that culture testing should have been conducted in the isolator prior to the initiation of compounding to ensure the area was free of organisms and/or mold.<br><br>b. Review of environmental testing completed by company #**1** (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the off-site IV Infusion Center rooms where compounding was conducted in an isolator, identified mold growth in various areas within the room in both air and surface sampling. Mold growth was identified in October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth | A 043 | Applies to Tag A 043 (a):<br>Prior to re-opening of the Saint Mary's Outpatient Chemotherapy Center, culture testing will be conducted before compounding resumes. Connecticut Department of Consumer Protection, DPH Fire and Safety Surveyor and the DPH will validate all requirements of USP797 at this location prior to resuming compounding activities.<br><br>Monitoring:<br>Initial compounding date to be determined once plan for re-opening site is identified.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A 043 (b):<br>Transport and Transfer of chemotherapy medications policy completed during survey and approved by the Department of Consumer Protection surveyor.<br><br>Monitoring:<br>Not applicable | To Be Determined<br><br>August 21, 2015 |

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| A 043 | Continued From page 4<br>were also identified on a surface area in the negative pressure room in January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3112/15, 4/30/15, and on 5/28115 in the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation at the infusion center on that day. Interview with the Director of Pharmacy on 8/18/15 at 10:00 AM indicated the compounded sterile preparations (CSP) were couriered over from the main hospital campus so that services would not be interrupted, however, a standard operating procedure for the transport and transfer of the CSP's had not been developed. Subsequent to the surveyor's inquiry the facility developed a written procedure for the transportation of CSP's that included monitoring of the temperature to ensure the efficacy of the medication was maintained.<br><br>c. Review of the culture results and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 1O:1O AM indicated !hat testing within the isolator was only conducted in one area within the unit and in one area of the antechamber. The Director of Pharmacy and the microbiologist identified they were not aware that additional sampling within the isolator/antechamber was necessary to be considered a comprehensive sample in accordance with USP 797.<br>d. Review of the facilities documentation failed to identify from October 2014 to April 2015 that the agar type (Trypticase Soybean Casein or Sabouraud Dextrose Agar) contained neutralizers for the surface samples as required by USP 797. | A 043 | Responsible Person:<br>Manager of Ambulatory Services<br><br>Applies to Tag A 043 (c):<br>Additional testing sites on a rotating basis have begun on the IV compounding hoods within the hospital campus. This procedure will be implemented at the Saint Mary's Outpatient Chemotherapy Center at the time of re-opening the compounding units.<br><br>Monitoring:<br>Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A 043 (d):<br>Environmental company asked to ensure that neutralizing specifications be added to the environmental report.<br><br>Monitoring:<br>IV Compounding Committee will review all environmental reports as they are submitted.<br><br>Responsibility:<br>Director of Pharmacy | September 30, 2015<br><br>On-going<br><br>May 28, 2015<br><br>On-going |

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| A 043 | Continued From page 5<br><br>e. Further review of the facility documentation failed to identify a lot number and expiration date on the EM testing reports from October 2014 to Dec 2014 and/or the incubation dales from October 2014 lo July 23, 2015.<br><br>f. On 4/30/15 and 5/28/15 mold was Identified In both the negative and positive pressure room in both surface and air sampling. The action plan was to assess if the air flow had been adjusted, discuss a HEPA filter upgrade, to obtain a hood peridox sporicidal cleaner to use daily on the counter tops, and terminal cleaning with an alternate bleach product. The Director of Pharmacy indicated he was not aware if the air flow was adjusted, and the new HEPA filtration system that was proposed had not been accepted to date of this interview.<br><br>g. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from September of 2014 through March of 2015 Company #2 was utilized for daily cleaning of the compounding rooms. The hospital failed to demonstrate that a surveillance program was In place to ensure quality services were provided subsequent to the identification of mold growth in the compounding **rooms.**<br><br>h. In March of 2015 the daily cleaning company was changed to a Company #3, a hospital grade company to assess for improvements with mold and bacteria cultures within the positive and negative pressure rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from March of 2015 through June of 2015 the | A 043 | Applies to Tag A 043 (e):<br>Environmental company asked to ensure that environmental reports include lot number and expiration dates.<br><br>Monitoring:<br>Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A 043 (f):<br>A Multi-disciplinary committee was implemented to review and document all aspects of USP79 including any corrective action plans, reports of environmental concerns and implementation of any business plan to upgrade the IV compounding facilities at the hospital campus and outpatient center. The Committee consists of Pharmacy Management, Environmental Services, Facilities Management, Microbiologist, Infection Prevention Physician, Quality Management and Regulatory Compliance.<br><br>Monitoring:<br>All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent to the Quality Committee of the Board the subsequent month for review.<br><br>Responsibility:<br>Director of Pharmacy | August 3, 2015<br><br>On-going<br><br>August 26, 2015<br><br>On-going |

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| A 043 | Continued From page 6<br>facility failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth in the compounding rooms.<br><br>Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of Pharmacy on 8/24/15 Indicated that hospital staff provided the terminal cleaning which Included all surfaces in the compounding rooms with the exception of the isolators. The hospital failed to provide evidence that staff who performed the cleaning were trained and/or the type of cleaning products/supplies utilized were documented. Further interview with the Manager of Clinical Quality/Regulatory Affairs stated that surveillance was not completed to ensure terminal cleaning was conducted properly. | A 043 | Applies to Tag A043 (g, h & i):<br>Competency of contracted cleaning service, including product handling, equipment evaluation and procedure compliance to be completed.<br>Competency of hospital staff of terminal cleaning has been completed.<br>Monitoring: Any environmental report reflecting positive contamination, a competency will be performed weekly until the environmental report returns negative.<br><br>Responsibility:<br>Director of Environmental Services | Oct 15, 2015<br><br>On-going |
| | j. Interview and tour of the compounding rooms with the Director of Engineering on 8/17/15 at 10:45AM identified the negative and positive pressure rooms failed to have a thermostat to ensure the temperature of the room was within an acceptable range for mediations to be stored. Medications were transferred to the main hospital pharmacy on 6/13/15. Interview with the Facilities Director and the Director of Pharmacy indicated on 7/11/15 they were informed the air conditioning unit in the infusion center was turned off at night and on the weekends. During the period of 9/4/14 through 6/30/15 the facility failed to have a mechanism in place to monitor the temperature of the rooms where the medications were stored to ensure efficacy of the medications were maintained in accordance with the manufacturers recommendation. Subsequent to the surveyors inquiry the facility implemented a procedure entitled Monitoring Medication Room. | | Applies to A043 (j):<br>Digital thermometers temporarily installed into the negative and positive pressure rooms for temperature monitoring. Plan to implement automated climate controls/monitoring in both rooms. Business plan approved, pending implementation of construction.<br>Policy/procedure completed during survey and approved by CT Consumer Protection surveyor.<br><br>Monitoring:<br>Temperature monitored twice daily in both the negative and positive pressure rooms weekdays and recorded in log. Log audited by Manager monthly.<br><br>Responsible:<br>Manager of Ambulatory Services | August 28, 2015<br><br>August 18, 2015<br><br>December 1, 2015 |

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| A 043 | Continued From page 7<br>Temperatures.<br><br>k. Interview with the Manager of the Infusion Center and the Director of Engineering identified the Infusion Center failed to have generator and did not have a plan if the power source was absent for the compounding areas. Subsequent to the surveyors inquiry an operating procedure entitled Power Outage was implemented that directed in part that the property manager of the facility would notify the manager of the infusion center and the Director of the Pharmacy of any power outage to assess and determine if medications need to be transported to the main campus of the hospital.<br><br>l. Interview and tour of the compounding rooms on 8/17/15 at 11:00 AM with the Director of Engineering failed to identify pressure senor alarms or alarms for the exhaust fan were present in accordance with hospital policy. Review of the hospital policy entitled IV Room Infection Control directed in part that both the IV room and the barrier Isolators would be monitored and alarmed for proper pressure range. If the alarms sounded, the hospital facilities department would be contacted.<br>Interview with the Director of Engineering on 8/20/15 at 4:00 PM identified he was responsible to ensure a thermometer, pressure senor and exhaust fan alarms were present in the positive and negative pressure rooms and a plan for a power outage and did nol.<br><br>Review of the job description for the Director of Engineering identified his/her responsibilities in part directed the management of the physical plant, electrical and medical gas delivery systems, emergency generators and project | A 043 | Applies to A042 (k):<br>Power outage policy developed during on site survey and approved by surveyor from the CT Department of Consumer Protection. Procedure established notification system by the Leever Center building Management to Manager and Supervising Physician of Outpatient Chemotherapy Center. Determination to transport medications from outpatient center to hospital storage (utilizing transport protocol) to be determined by Pharmacy management.<br>Monitoring:<br>Pharmacy management and Manager of Ambulatory Services to report any known power outages to IV Compounding Committee as they occur.<br>Responsibility:<br>Manager of Ambulatory Services<br><br>Applies to A042 (l):<br>Alarms for exhaust fans are being installed to alert users and Facilities to any interruptions per business plan. Pending construction implementation.<br><br>Monitoring:<br>The IV Compounding Committee to ensure the business plan for improvements is implemented.<br><br>Responsibility:<br>Director of Facilities | August 28, 2015<br><br>On-going<br><br>Date of installation to be determined. |

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| A 043 | Continued From page 8<br>management. In addition the Director of Engineering supervises general contractors, evaluates locates and recommends equipment and systems for replacement or upgrades, provides oversight for the development and implementation of an overall emergency management strategy for the hospital, applies practical knowledge for the operation of air conditioning and heating systems and meets with contractors to plan, organize, coordinate and communicate programs, services policies and procedures.<br><br>m. During an interview on 8/18/15 at 10:30 AM, the Director of Pharmacy, the hospital's microbiologist and the Director of Facilities indicated they had meetings each time culture results were received with the Director of Environmental Services to discuss the mold/bacteria issues in the Infusion Center however, documentation did not support this. An interview with the Director of Environmental Services was unable to be scheduled as he was on a medical leave.<br><br>n. During interview on 8/18/15 at 10:40 AM, the hospital microbiologist and the Director of Pharmacy identified mold issues were discussed at each monthly infection control meeting in the attendance of MD #1 who was the infection control physician. MD #1 indicated on 8/18/15 at 4:39 PM he was not aware that mold even in small amounts exceeded the USP 797 threshold. Further interview with MD #1 and the hospital mlcrobiologist Indicated that speciation was not conducted until January of 2015 and would be important for identification of the bacteria/mold to determine an appropriate action plan. MD #1 and the hospital microbiologist could identify why the | A 043 | Applies to A 043 (m):<br>Formal documentation of the meeting of the IV Compounding meeting implemented.<br><br>Monitoring:<br>All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent the subsequent month to the Quality Committee of the Board for review.<br><br>Responsibility:<br>Manager of Clinical Quality and Regulatory Affairs<br><br>Applies to A 043 (n):<br>Speciation initiated January 2015. IV Compounding Committee will ensure that the presence of any reported mold, even in small amounts, will have an appropriate plan to address the findings. | August 26, 2015<br><br>On-going |

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| A 043 | Continued From page 9<br>speciation was not conducted from September through December of 2014. Review of the infectious disease physician's duties and responsibilities included to oversee the infection control department.<br><br>Interview and review *of* the Governing Body Minutes from September 2014 through June 2015 with the Chief Nursing Officer (CNO) on 8/24/15 at 1:00 PM identified the Chief Medical Officer (CMO) presented the report of the Quality and Safety Committee minutes to the Governing body however the minutes failed to reflect any acknowledgement that during that period of time, the hospital's outpatient infusion center had grown mold within the compounding areas that exceeded the USP 797 guidelines. In addition the minutes failed *to* reflect the infusion center ceased compounding on 6/30/15 due to mold in the antechamber *of* the isolator. Further interview with the CNO indicated he did not inform the Governing body of the positive cultures In the infusion center as remediation was in place and although compounding operations ceased on 6/30/15 patient care was not Interrupted.<br><br>Interview with the CMO on 8/24/15 at 1:10 PM indicated he was not aware that the positive culture results in the infusion center exceeded USP 797 thresholds and/or that compounding had ceased in that area as of 6/30/15. The CMO indicated that he would have expected to be notified.<br><br>Review *of* the hospital's Pharmacy and Therapeutics Committee functions in part directed to advise the medical staff and hospital administration in all matters pertaining to the use of drugs. | A 043 | Monitoring:<br>Will ensure that any positive environmental reports require clinical review by the Chief of Infection Prevention with recommendations and action by the IV Compounding Committee.<br><br>Responsible Person:<br>Director of Pharmacy<br><br>Applies to A043 (n) con't:<br>Note of correction: the CMO was not interviewed. This should be amended to Chief of Staff (COS) and Chairman of the Quality Committee of the Board.<br><br>Previously the Director of Pharmacy reported compounding activities quarterly to the Infection Prevention Committee which were documented and the minutes shared with the Governing Board. Immediately, Pharmacy will begin reporting compounding activities monthly to the IP Committee and the minutes will be shared with the Governing Board at the subsequent Board meeting.<br><br>Monitoring:<br>Infection Prevention minutes to be distributed at the Quality Committee of the Board.<br><br>Responsible Person:<br>Chief Nursing Officer and Vice President of Quality | On-going<br><br>September 15, 2015<br><br>October 1, 2015 |

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| A 083 | 482.12(e) CONTRACTED SERVICES<br><br>The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.<br><br>This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, interviews and policy review, the Governing Body failed to ensure that quality services were rendered by contracted company's to conduct environmental testing and/or certification of the compounding rooms and/or that staff recognized that reports submitted by numerous company's were complete/accurate. The findings included:<br><br>a. The infusion center was opened by the hospital on 9/4/14. Review of hospital documentation failed to provide evidence from September 2014 through December 2014 that the compounding rooms were negative and positive.<br><br>b. Review of the report dated 8/20/15, submitted by Company #4, to the Director of Engineering identified that the positive pressure room did not meet the minimum requirement in USP797. The room had only 0.012 of pressure and the minimum requirement is 0.02. Also, it was found that the negative pressure room was drawing air Into the room from the return in the ceiling. The Director of Engineering failed to respond to the | A 083 | Applies to A 083 (a):<br>The multi-disciplinary IV Compounding Committee will ensure adherence to USP797 protocols. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance.<br>Negative and positive pressure IV compounding rooms will be tested annually per policy. All maintenance activities associated with IV compounding has been entered into a jointly shared calendar to be shared by the IV Compounding committee which will ensure compliance.<br>Monitoring:<br>IV compounding Committee to review IV compounding maintenance calendar monthly to ensure timely compliance.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to A 083 (b):<br>Return room duct has been removed from negative pressure room.<br><br>Monitoring: NA<br><br>Responsible Person:<br>Director of Facilities | October 7, 2015<br><br>On-going<br><br>September 9, 2015 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/21/2015
FORM APPROVED
OMB NO 0938-0391

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| A083 | Continued From page 11<br>abnormal report.<br><br>Review of the certification report test dated 9/2/14, provided the following information:<br><br>c. As per the manufacturer, there are 2 supply and 2 exhaust HEPA filters (total of four) In the CACI. The test report documented that only leak tested one HEPA filter and listed the exhaust as non-applicable. There was no way to determine if the other three were leak tested before compounding began inside the CACI (chemotherapy hood),<br><br>d. There were two chambers to the isolator with two gauges showing the pressure in each chamber (ante chamber or the pass through and compounding chamber). Only !he barrier isolator pressurization or compounding chamber was documented In the certification.<br><br>e. The pressure measured inside the isolator is listed as 0.34 inches of water column. A CACI Is used for chemotherapy compounding and is a negative pressure isolator as seen in the physical inspection on 8117/15 where the dials for both the chambers read negative pressure. But the report lists the pressure inside as positive pressure and incorrectly lists the manufacturer specifications as 0.01.<br><br>f. The alarm assessment test is marked as not applicable. Since there is an alarm on the CACI, there is no reason given that it was not tested.<br><br>g. The certification does not list If it was done under dynamic conditions as required under USP797, | A 083 | Applies to A 083 **(c) through (l):**<br>Agreement with former hood Certification Company terminated. New hood certification company agreement in place.<br>In-service of USP797 documentation requirements to take place between hood certifier and IV Compounding Committee.<br><br>Monitoring:<br>IV compounding Committee to review all certification and environmental reports for accuracy as they are submitted.<br><br>Responsible Person:<br>Director of Pharmacy | Septem ber 15, 2015<br><br>Septem ber 30, 2015<br><br>On-going |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEIJICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIOERISUPPUER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WJNG | (X3) DATE SURVEY COMPLETED |
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| A 083 | Continued From page 12<br><br>h. Under overall certification, the box for fail is crossed off. The pass box is filled in. There is a note that there is an issue with the units magnehelic gauge which measures the pressure inside the isolator.<br><br>i. The report shows that 4 HEPA filters were leak tested-2 exhaust and 2 supply filters. According to the manufacturer there is only one supply filler. The certification does not match the manufacturer specifications.<br><br>j. The alarm assessment test is marked as not applicable. Since there is an alarm on the CAI for low pressure, there is no reason given that it was not tested.<br><br>k. The pressure lest indicates a negative 0.38 Inches of water column in the barrier isolator and the pass through. This is a CAI which is a positive pressure isolator therefore the pressure should not be negative. Even the manufacturer specifications are listed incorrectly as negative 0.02 for both the chambers_ | A 083 | | |
| | l. The certification does not list if it was done under dynamic conditions as required under USP797.<br><br>m. The pre-filters of the isolators are changed every 3 months. The CACI pre-filters are dated 3/25/15 of when they were changed but there is no date on the CAI prefilters. This Is done by an outside vendor that also does changes the fillers in the entire hospital. There is no way to determine when the prefilters at the off-site infusion center were changed since the invoices | | Applies to A 083 (m):<br>All maintenance activities associated with IV compounding has been entered into a jointly shared calendar to be shared by the IV Compounding committee which will ensure compliance.<br>Monitoring:<br>IV compounding Committee to review IV compounding maintenance calendar monthly to ensure timely compliance.<br><br>Responsibility:<br>Manager of Ambulatory Services | October 7, 2015<br><br>On-going |

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| A 083 | Continued From page 13<br>are done by listing all the filters changed and does not provide specifically where these filters are located.<br><br>Interview with the Director of Pharmacy on 8/18/15 indicated when the certifications reports were issued, hospital staff failed to identify the aforementioned abnormalities and/or contacted company #5 (certified the isolators). At the time of this inspection, there was no report showing if the CAI had even passed certification when compounding was started on 9/4/15. | A 083 | | |
| A 283 | 482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES<br><br>(b) Program Data<br>(2) [The hospital must use the data collected to -<br><br>(ii) Identify opportunities for improvement and changes that will lead to improvement.<br><br>(c) Program Activities<br>(1) The hospital must set priorities for its performance improvement activities that--<br>(i) Focus on high-risk. high-volume, or problem-prone areas;<br>(ii) Consider the incidence, prevalence, and severity of problems in those areas: and<br>(iii) Affect health outcomes, patient safety, and quality of care.<br><br>(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. | A 283 | | |

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| A 283 | Continued From page 14<br>This STANDARD is not met as evidenced by: Based on a review of hospital documentation, interviews and policies, the hospital failed to develop quality performance Improvement activities regarding high risk area's Including the IV infusion center (offsite location). The finding includes the following:<br><br>The infusion center was opened by the hospital on 9/4/14. Review of environmental testing completed by Company #1 (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the off-site IV Infusion Center rooms where compounding was conducted in an isolator, identified mold growth in various areas within the room in both air and surface sampling Mold growth was identified in October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth were also identified on a surface area in the negative pressure room in January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3/12/15, 4/30/15, and on 5/28/15 in the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation al the infusion center on that day.<br><br>a. Review of the Infection prevention committee meeting minutes during the period of September 2014 through June 2015 failed to indicate that surveillance activities were conducted subsequent to the identification of mold growth. Review of the Infection prevention committee functions in part. determines the mechanism for | A 283 | Applies to Tag A283:<br>A multi-disciplinary IV Compounding Team has been implemented to ensure oversight of IV compounding activities. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. Committee The team will be responsible for adherence to USP797 regulations.<br><br>Monitoring:<br>Activities will be reported to Infection Preventions, Pharmacy & Therapeutics Committee and the Quality Committee of the Board.<br><br>Responsible Person:<br>Director of Pharmacy | Aug 26, 2015<br><br>On-going |

| STATEMENT OF DIFIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPUER/CUA. IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B WING | {X3) OATE SURVEY COMPLETED C |
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| A 283 | Continued From page 15<br>effective surveillance for hospital-acquired infections. Cultures would be conducted whenever necessary for environmental or patient surveillance. Recommendations for corrective actions woL1ld be implemented whenever necessary. | A 283 | | |
| A 490 | 482.25 PHARMACEUTICAL SERVICES<br><br>The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.<br><br>This CONDITION is not met as evidenced by: Based on a review of hospital documentation, policies and interviews, it was determined that the hospital failed to meet the Condition of Participation for Pharmaceutical Services. The findings included:<br><br>1. The hospital failed to ensure the Pharmacy department was in compliance with federal and state laws (USP-797) and/or that the Director recognized questionable performance standards provided by contracted services that provided environmental testing and certification at the IV infusion center from 9/4/14 through 6/30/15. Refer to A-492 and A-501. | A490 | Applies to Tag A 490:<br>A multi-disciplinary IV Compounding Team has been implemented to ensure oversight of IV compounding activities. Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance. The team will be responsible for adherence to USP 797 regulations.<br><br>Monitoring:<br>Activities will be reported monthly to Infection Prevention, Pharmacy & Therapeutics and Quality Committee of the Board.<br><br>Responsible Person:<br>Director of Pharmacy | August 26, 2015<br><br>On-going |
| A 492 | 482.25(a)(1) PHARMACIST RESPONSIBILITIES<br><br>A full-time, part-lime, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy | A 492 | | |

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| A 492 | Continued From page 16<br>services.<br><br>This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contractor reports. interviews, and policy review, the hospital failed to provide the necessary supervision of Pharmacy services to ensure that IV compounding rooms were tested/certified in accordance with federal and state laws (USP-797) and/or that culture testing was conducted prior to the initiation of compounding and/or that culture testing was comprehensive and/or that inaccurate reports were recognized and addressed. The findings include:<br><br>The infusion center was opened by the hospital on 9/4/14. Review of reports completed by Company #1 (contracted service who provided environmental testing) during the period of October 2014 through June 2015 for the IV Infusion Center rooms where compounding was conducted in an isolator identified mold growth in various areas within the room in both air and surface sampling. Mold growth was identified In October, November, and December of 2014 additionally in January and February of 2015. Twenty nine colonies of bacterial growth were also identified on a surface area in the negative pressure room In January of 2015. No actionable issues were identified on March 5th 2015 however mold was identified again on 3/12/15, 4/30/15, and on 5/28/15 In the room where the isolators were located. On June 25th 2015 mold was identified in the antechamber of the isolator in the negative pressure room. Tests results were provided to the facility on 6/30/15 and intravenous compounding ceased operation at the infusion | A 492 | | |

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| A 492 | Continued From page 17<br>center on that day.<br><br>a. Review of hospital documentation failed to provide evidence that culture testing was conducted in the isolator prior to the initiation of compounding. Review of the environmental reports and inte1View with the Director of Pharmacy and the hospital's microbiologist on 8/18/15 at 10:10 AM identified they were not aware that culture testing should have been conducted in the isolator prior to the initiation of compounding to ensure the area was free of organisms and/or mold.<br><br>b. Inte1View with the Director of Pharmacy on 8/18115 at 10:00 AM Indicated the compounded sterile preparations (CSP) were couriered over from the main hospital campus when compounding ceased, so that services would not be interrupted, however, a standard operating procedure for the transport and transfer of the CSP's had not been developed. Subsequent to the su1Veyor's inquiry the facility developed a written procedure for the transportation of CSP's that included monitoring of the temperature to ensure the efficacy of the medication was maintained.<br><br>c. Review of the culture results and interview with the Director of Pharmacy and the hospital's microbiologist on 8/18115 at 10:10 AM indicated that testing within the Isolator was only conducted in one area within the unit and In one area of the antechamber. The Director of Pharmacy and the microbiologist identified they were not aware that additional sampling within the isolator/antechamber was necessary to be considered a comprehensive sample in accordance with USP 797. | A 492 | Applies to Tag A 492 (a):<br>Prior to re-opening of the Saint Mary's Outpatient Chemotherapy Center, culture testing will be conducted before compounding resumes. Connecticut Department of Consumer Protection, DPH Life Safety Surveyor and DPH will validate all requirements of USP797 at this location prior to resuming compounding activities.<br><br>Monitoring:<br>Initial compounding date to be determined once plan for re-opening site is identified.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A 492 (b):<br>Transport and Transfer of chemotherapy medications policy completed during survey and approved by the Department of Consumer Protection surveyor.<br><br>Monitoring:<br>Not applicable<br><br>Responsible Person:<br>Manager of Ambulatory Services<br><br>Applies to Tag A 492 (c):<br>Additional testing sites on a rotating basis have begun on the IV compounding hoods within the hospital campus. This procedure will be implemented at the Saint Mary's Outpatient Chemotherapy Center at the time of re-operationalizing the compounding units. | To be determined<br><br>August 25, 2015<br><br>September 30, 2015 |

| STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION | (XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | {X2) MULIIPLE: CONSTRUCTION | (X3} DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CI1Y, STATE, ZIP CODE |
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| SAINT MARYS HOSPITAL | 56 FRANKLIN ST<br>WATERBURY, CT 06706 |

| {X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVJDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS·REFERENCED TO THE APPROPRIATE OEFICIENCYJ | (X5) COMPLETION DATE |
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| A492 | Continued From page 18<br><br>d. Review of the facilities documentation failed to identify from October 2014 to April 2015 that the agar type (Trypticase Soybean Casein or Sabouraud Dextrose Agar) contained neutralizers for the surface samples as required by USP 797.<br><br>e. Further review of the facility documentation failed to identify a lot number and expiration date on the EM testing reports from October 2014 to Dec 2014 and/or the incubation dates from October 2014 to July 23, 2015.<br><br>f. On 4/30/15 and 5/28/15 mold was identified in both the negative and positive pressure room in both surface and air sampling. The action plan was to assess if the air flow had been adjusted, discuss a HEPA filler upgrade, to obtain a hood peridox sporicidal cleaner to use daily on the counter tops, and terminal cleaning with an alternate bleach product. The Director of Pharmacy indicated he was not aware if the air flow was adjusted, and the new HEPA filtration system that was proposed had not been accepted to date of this interview.<br><br>g. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from September of 2014 through March of 2015 Company #2 was utilized for daily cleaning of the compounding rooms. The hospital failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth In the compounding rooms.<br><br>h. In March of 2015 the daily cleaning company was changed to a company #3, a hospital grade | A492 | Con't Tag A 492 (c):<br>Monitoring:<br>Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A 492 (d):<br>Environmental company asked to ensure that neutralizing specifications added to the environmental report.<br><br>Monitoring:<br>IV Compounding Committee will review all environmental reports as they are submitted.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A 492 (e):<br>Environmental company asked to ensure that environmental reports include lot number and expiration dates.<br><br>Monitoring:<br>Environmental testing completed monthly on operating units. The IV Compounding Committee is reviewing all environmental reports monthly.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A 492 (f):<br>A Multi-disciplinary committee was implemented to review and document all aspects of USP79 including any corrective action plans, reports of environmental concerns and implementation of any | On-going<br><br>August 3, 2015<br><br>On-going<br><br>August 3, 2015<br><br>On-going<br><br>August 26, 2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDERJSUPPUER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| | 070016 | | C 09/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SAINT MARYS HOSPITAL | 56 FRANKLIN ST<br>WATERBURY, CT 06706 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | 10 PREFIX TAG | PROVJOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS·REFERENCEO TO THE APPROPRIATE DEFICIENCY) | (XS) COMPLETION DATE |
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| A 492 | Continued From page 19<br>company to assess for improvements with mold and bacteria cultures within the positive and negative pressure rooms. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of the Pharmacy on 8/24/15 identified from March of 2015 through June of 2015 the facility failed to demonstrate that a surveillance program was in place to ensure quality services were provided subsequent to the identification of mold growth in the compounding rooms.<br><br>i. Interview with the Manager of Clinical Quality/Regulatory Affairs and the Director of Pharmacy on 8/24/15 indicated that hospital staff provided the terminal cleaning which included all surfaces In the compounding rooms with the exception of the isolators. The hospital failed to provide evidence that staff who performed the cleaning were trained and/or the type of cleaning products/supplies utilized were documented. Further interview with the Manager of Clinical Quality/Regulatory Affairs stated that surveillance was not completed to ensure terminal cleaning was conducted properly.<br><br>j. Interview and tour of the compounding rooms with Ithe Director of Pharmacy and the Director of Engineering on 8/17/15 at 10:45 AM identified the negative and positive pressure rooms failed to have a thermostat to ensure the temperature of the room was within an acceptable range for medications to be stored. Medications were transferred to the main hospital pharmacy on 6/30/15. Interview with the Facilities Director and the Director of Pharmacy indicated on 7/1/15 they were informed the air conditioning unit in the infusion center was turned off at night and on the weekends. During the period of 9/4/15 through 6/30/15 the facility failed to have a mechanism In | A 492 | Cont Tag A 492 (f):<br>business plan to upgrade the IV compounding facilities at the hospital campus and outpatient center. The IV Compounding Committee consists of Pharmacy Management, Facilities Management, Environmental Services Management, Infection Prevention physician, Microbiologist, Quality Management and Regulatory Compliance.<br><br>Monitoring:<br>All IV Compounding Committee minutes to be reviewed at Infection Prevention Committee monthly. Infection Prevention will have an IV compounding standing agenda item monthly and all IP minutes will be sent to the Quality Committee of the Board the subsequent month for review.<br><br>Responsibility:<br>Director of Pharmacy<br><br>Applies to Tag A492 (g, h & i):<br>Competency of contracted cleaning service complete, including product handling, equipment evaluation and procedure compliance. Competency of hospital staff performing terminal cleaning of IV compounding rooms completed.<br><br>Monitoring:<br>Any environmental report reflecting positive contamination, a competency will be performed weekly until the environmental report returns negative<br>Responsibility:<br>Director of Facilities<br><br>Applies to A492 (j):<br>Digital thermometers temporarily installed into the negative and positive pressure rooms for temperature monitoring. Plan to implement automated climate controls/monitoring in both rooms pending business plan implementation.<br>Policy/procedure completed during survey and approved by CT Consumer Protection surveyor. | On-going<br><br>October 15, 2015<br><br>September 30, 2015<br><br>August 18, 2015 |

| STATEMENT OF DEFICIENCIES AND PIAN OF COHRECTION | {X1) PROVtDER/SUPPLIERICLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SAINT MARYS HOSPITAL | 56 FRANKLIN ST<br>WATERBURY, CT -06706 |

| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | JD PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XS) COIPLETION DAT€ |
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| A 492 | Continued From page 20<br>place to monitor the temperature of the rooms were the medications were stored to ensure efficacy of the medications were maintained in accordance with the manufacturers recommendations. Subsequent to the surveyors inquiry the facility implemented a procedure entitled Monitoring Medication Room Temperatures.<br><br>k. interview with the Director of Pharmacy, the Manager of the Infusion Center and the Director of Engineering Identified the Infusion Center failed to have generator and did not have a plan if the power source was absent for the compounding areas. Subsequent to the surveyors inquiry an operating procedure entitled Power Outage was implemented that directed in part U1at the property manager of the facility would notify the manager of the infusion center and the Director of the Pharmacy of any power outage to assess and determine if medications need to be transported to the main campus of the hospital.<br><br>l. Tour of the compounding rooms on 8/17/15 at 11:00 AM and interview with the Director of Pharmacy and the Director of Engineering failed to identify pressure senor alarms or alarms for the exhaust fan were present in accordance with hospital policy. Review of the hospital policy titled IV Room Infection Control directed in part that both the IV room and the barrier Isolators would be monitored and alarmed for proper pressure range. If the alarms sounded, the hospital facilities department would be contacted.<br><br>Review of the hospital's Pharmacy and Therapeutics Committee functions in part directed to advise the medical staff and hospital administration in all matters pertaining to the use | A 492 | Cont' A 492 (j):<br>Monitoring:<br>Temperature monitored twice daily in both the negative and positive pressure rooms weekdays and recorded in log. Log audited by Manager monthly.<br><br>Responsible:<br>Manager of Ambulatory Services<br><br>Applies to A492 (k):<br>Power outage policy developed during on site survey and approved by surveyor form the CT Department of Consumer Protection. Procedure established notification system by the Leever Center building Management to Manager and Supervising Physician of Outpatient Chemotherapy Center. Determination to transport medications from outpatient center to hospital storage (utilizing transport protocol) to be determined by Pharmacy management.<br><br>Monitoring:<br>Pharmacy management and Manger of Ambulatory Services to report any known power outages to IV Compounding Committee as they occur.<br><br>Responsibility:<br>Manager of Ambulatory Services<br><br>Applies to A492 (l):<br>Alarms for exhaust fans are being installed to alert users and Facilities to any interruptions per business plan implementation. Pending construction implementation.<br><br>Monitoring:<br>The IV Compounding Committee to ensure the business plan for improvements is implemented. | December 1, 2015<br><br>August 28, 2015<br><br>On-going<br><br>Date of installation to be determined . |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 091211 2015
FORMAPPROVED
OMB NO 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIOER/SUPPUERICLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. I3UJLDING B. WING | (X3) DATE SURVEY COMPLETED C |
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| SAINT MARYS HOSPITAL | 66 FRANKLIN ST<br>WATERBURY, GT 06706 |

| (X4) ID PREFIX TAG | SUMMA.RY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAH OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X) COfdPLETION DATE |
|---|---|---|---|---|
| A 492 | Continued From page 21<br>of drugs_<br><br>Review of the job description for the Director of Pharmacy included in part the initiative to acquire knowledge, to stay currently Informed in the area and fields which are applicable to this position. Works collaboratively with other departments to meet the needs of the hospital. | A492 | | |

# EXHIBIT S4

POLICY #425.1

Subject: Saint Mary's CARE Policy

Effective Date: July 1, 2013

Revised: August 19, 2015

Replaces: Saint Mary's Financial Assistance Policy (FAP)

PURPOSE

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under Federal, State and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their ability to pay. The underlying theory is that a person, for a reasonable period of time can only be expected to pay a maximum percentage of their disposable income towards charges incurred. Any "self-pay" balance in excess of this amount would place an undue financial hardship on the patient or their family and "may" be adjusted off as Financial Assistance.

POLICY

Recognizing its charitable mission, it is the policy of the hospital to provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care. Discounted care will be provided to uninsured or underinsured patients who meet the established eligibility criteria and complete the required application (all components in a timely manner) and review process.
All emergency and medically necessary services provided by this facility will be available as uncompensated services.

1. All self-pay accounts will be eligible for 40% self-pay discount, off of the published charges, regardless of their income or assets. Accounts must be in the Self-Pay Financial Class for the discount to be taken.
2. All self-pay accounts could be eligible for 100% discount if the household income is less than 200% of the Federal Poverty Level.
3. In addition to the 40% discount stated above, self-pay accounts may be eligible for an additional 25% discount, up to a maximum of 65%, if their income falls between 200% – 400% of the Federal Poverty Income level.
4. Elective cosmetic procedures are not eligible for charity care.
5. Insured patients with balances, due to deductibles, co-payments, or co-insurance, non-covered charges may be eligible for charity care if their income falls between 200% - 400% of the Federal Poverty Level.
6. Self-pay patients could be eligible for charity care write-offs based on their "Propensity to Pay".

7. A patient may only request Charity Care while the account is still active receivable.
8. Incomplete applications and falsified applications will not be considered eligible for Charity Care.
9. Patients gross income and family size will be considered in determining eligibility for Charity Care.
10. Patients found eligible for Charity Care will be eligible for care for any balance due at the time of application approval and any medically necessary services within the six months prior to application approval date and six month post date of application approval.
11. Charity Care will be given at 400% of the Federal Poverty Income levels. A sliding fee scale will be applied between 200% - 400% of the Federal Poverty Income levels.
12. Signage (in 48 or 72 font) and one page summary describing STMH charity care policy will be in English, Spanish, Portuguese, and Albanian, and placed in Registration, Emergency Department, all Social Services departments, Patient Financial Services (PFS), Cashiers office, Financial Advocate work area, and the Lobby.

DEFINITIONS:

Self-Pay
Self-pay patient is one who is financially responsible, either personally or as a guarantor, for the payment of the charges associated with the health care services provided by Saint Mary's Hospital.

Medical Necessity
Medical Necessity is, hospital care that is rendered either inpatient or outpatient, in order to diagnose, alleviate, correct, cure, or prevent the worsening or onset of a condition that endangers, could result in suffering or pain or may cause malfunction or aggravate a handicap.

Emergency Care
Emergency Care is immediate care provided to avoid causing serious jeopardy to patient's health, or causing serious impairment to body that could result in dysfunction of any organ or body parts.

Amount Generally Billed
Amount Generally Billed (AGB), means the amount generally billed to insured patients for emergent or medically necessary care as determined by the hospital's published charges at the time of billing multiplied by the hospital's most current relationship of costs to charges as taken from the hospital's most recent annual financial filing with the Office of Health Care Access.

Uninsured Patient
Saint Mary's Healthcare (SMH) defines an Uninsured Patient as:

a. Whose income is between 200% - 400% of the Federal Poverty Income levels;
b. Who has applied and been compliant in the eligibly process and has been denied eligibility for any medical or health care coverage;
c. Who is not eligible for coverage under Medicare, Tricare, or any other Federal programs, or privately sponsored health or accident insurance, including, but not limited to, workers' compensation, settlements or judgments arising from suits, claims or proceedings involving motor vehicle accidents or alleged negligence; and
d. Who is liable for one or more hospital charges.

Charity

Charity is the demonstrated inability of a patient to pay. Charity care does not include bad debt, contractual adjustments, or unreimbursed costs from other community services. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity and bad debt. If the patient is able but unwilling to pay, the hospital will classify the account as bad debt.

Bad Debt
Bad debts are the unwillingness of the patient to pay. It may be included in charity care, provided the patient meet the Federal Poverty Income guidelines and provides the necessary documents, to support the income levels.

Earned Income
Earned income is the sum of all household wages or salaries received on weekly, monthly, or yearly bases.

Catastrophic Illness
Catastrophic illness is any medical condition, either acute or chronic, which incurred expenses that are not fully covered by private insurance, state, federal programs, or other sources. This will also include expenses that exceeded the patient's maximum benefits. Patient will be eligible for discount consideration, as catastrophic, if their outstanding balance exceeds 25% of their gross monthly income.

Propensity to Pay
This is the verification of patient's Ability to Pay their medical bill, based on their estimated income, and their Likelihood to Pay, based on their credit score risk. These two indicators are combined to determine appropriate financial clearance.

PROCEDURE:

1. Charity and discounted care include services provided to the following:
    a. Uninsured or underinsured low-income patients who do not have the ability to pay all or part of their bill as determined by the financial guidelines in this policy;
    b. Insured patients whose coverage is inadequate to cover a catastrophic situation;
    c. Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large (as defined earlier in the definitions section) medical bills; and
    d. Patients deemed medically indigent by virtue of their documented eligibility for Medicaid benefits.

2. For emergency and medically necessary services provided to uninsured patients, and whose income are between 200% - 400% of the Federal Poverty Income Levels, SMH will reduce their bill in accordance with the guidelines provided by IRS 501(r)(5).

3. The following factors are to be considered when determining the amount of charity service for which a patient is eligible at the time of service:
    a. The patient's individual or family income, as appropriate, using the income guidelines as published by the Federal Government on April 1 each year (Federal Income Guidelines;
    b. Family size; and
    c. All other resources must be applied first, including third-party payers, Victims of Crime (i.e., a state-level program for crime victims to recover some hospital costs), and

Medicaid. If a patient does not have Medicaid but would qualify, he or she must cooperate with the application process. If the application is denied or is identified as ineligible based on the Medicaid income criteria, consider for charity and discounted care.

d. Propensity to Pay will be run as deemed necessary to qualify for charity care.

4. Determine the appropriate amount of charity service in relation to the amounts due after applying all other resources. A patient who can afford to pay for a portion of the services will be expected to do so. Note: A third party might pay part of an account, the patient may pay part, and another part might meet charity services. If the patient does not pay the amount deemed to be his or her responsibility, the uncollectible remainder would become bad debt.

5. Require evidence of eligibility. Documentation should be submitted within 14 days from the date of service (to include before and after the date of service). Additional time for completion of the application process may be extended as appropriate. The patient must provide supporting documentation of income, which can include the following:
    a. Paycheck, Social Security, pension, unemployment or disability check stubs, tax return, or other proof of income.
    b. The patient must sign the charity form.

6. Charity-care provisions will be reevaluated for a patient's eligibility when the following occur, it is the patients responsibility to bring this data forth to STMH for consideration:
    a. Subsequent rendering of services;
    b. Income change;
    c. Family size change;
    d. When any part of the patient's account is written off as a bad debt or is in collections; and
    e. When six months have passed since the last application or when circumstances change, whichever comes first.

7. Determine eligibility for charity service at the time of admission/pre-registration, or as soon as possible thereafter. In some cases, it can take investigation to determine eligibility, particularly when a patient has limited ability to provide needed information. Also, because of complications unforeseen at the time of admission, the patient may need to be reclassified as a full or partial charity.

8. Individuals who have questions about SMH charity care policy, or would like assistance with completing the application may contact our financial counselors, either in person, or by calling 203-802-8265.

9. Financial Counselors will initiate and approve/deny the application prior to submitting to the appropriate manager, based on account balance (See Number 11).

10. Patients will be notified in writing within 3 business days (Monday - Friday), from the date the "COMPLETED" application is received, regarding qualification for charity care, the remaining balance due, and any expected re-payment terms.

11. Financial Counselors will determine the write-off amount based on the aforementioned guidelines and the correct contractual allowance code. If the patient does not meet the financial criteria but has extenuating circumstances such as catastrophic illness, the account will be referred to the supervisor who will make a recommendation to the Manager/Director. Charity and discounted care

approval authority is as follows:

a. Write-offs from $.01 to $1,000 require approval by the appropriate Financial Advocate handling the account;
b. Write-offs from $1001 to $9,999 require approval by the Supervisor of Patient Access;
c. Write-offs from $10000 to $19,999 require approval by the Manager of Patient Access;
d. Write-offs $20,000 to $49,999 require approval by the Director of Patient Access;
e. Write-offs greater than $50,000 require approval by the Chief Financial Officer or Director of Finance.

12. Financial Counselors staff will ensure that patients and physicians are notified, in writing, regarding approval, denial, or pending status of uncompensated care. The notification will include the appeal process for any denied application.

13. The appeal process for denied charity and discounted care applications includes the following activities:
    a. Prompt notification of the denial and the specific reasons will be provided to each charity and discounted care applicant. The notification will also provide examples of additional information, which may be used to appeal the denial. Upon notification of the denial, the charity applicant will have 30 days to appeal the decision from the date of the denial letter.
    b. Additional information will be accepted by the provider and re-evaluated by the Supervisor/Manager.
    c. If the initial denial is upheld, prompt notification will be provided to the applicant.
    d. The Director of Patient Access or Director of Finance will review all denied appeals over $50,000. A written determination will be issued within 15 days of the receipt of the appeal.

14. The hospital will retain all charity and discounted care applications and supporting documentation within scanning for seven years.

15. The hospital will update the income eligibility criteria annually, April, using the Federal Poverty Guidelines (FPG) published by the Centers for Medicare & Medicaid Services (CMS). If CMS issues more than one update, the updated criteria shall become effective as of the issue date.

16. The base level for the charity and discount care income eligibility will be set at 40%.

17. Saint Mary's provides free x-rays and basic lab services, for patients that receive primary care services from the Malta House Van. Eligible patients are given a "Malta House" card. These services are written off at the time of billing. If patients are referred to SMH, under Malta House, for other services, they will be asked to complete a financial assistance application and if they are eligible for charity care, the charges will be adjusted appropriately. In order to prevent any billing statements being generated to these patients, a "hold" will be place on these accounts until the charity care determination is made.

18. A charity and discounted care budget will be established once a year during the annual budget process and submitted to the Board of Directors of Saint Mary's Hospital for approval. However, need for financial assistance will take priority over a fixed budget amount; the Board will be

promptly advised if charity and discounted care needs exceed the current budgetary provisions. A formal appeal process shall be implemented to permit rapid review of all appealed charity denials. The Director of Patient Access or Director of Finance shall review all final appeals of charity determinations.

## References

The AHA Board of Trustees Statement of Principles and Guidelines on Hospital Billing and Collection Practices (http://www.aha.org/content/12/120505-bill-collec-prac-statement.pdf);

Internal Revenue Code Section 501® requirements for tax-exempt hospitals (http://www.aha.org/advocacy-issues/tools-resources/advisory/2012/120716-legal-adv.pdf).

Creation Date: September 1, 2004
Revision Date: August 19, 2015
Key Content Expert:
JCAHO Reference:

EXHIBIT A: FINANCIAL ASSISTANCE APPLICATION

Saint Mary's HOSPITAL

Patient Name : _____ Date: _____

Current Address: Street_____

City, State, Zip _____

Phone # _____

Account(s)#: _____

Employer's Name & Address: _____

Spouse's Employer and Address: _____

Medical Insurance:_____ Policy/Claim#: _____

Insurance Company Name: _____

Address: _____

Number of Dependents (list ages, including self): _____

_____

Monthly Income (List source/amount): Patient's income_____

Spouse's income _____

Other income_____

I hereby attest that the above information is true and accurate. I understand that in order for me to be eligible, the information contained herein must be verified. I agree to provide Saint. Mary's Hospital with the necessary verifications, and, if requested by the Hospital, I agree to cooperate and follow through with application for State and/or Federal assistance as well as any other third party payors.

Patient/Guarantor: _____ Date: _____

Financial Counselor: _____ Approved by: _____ Date:_____

- All income must be verified. Please provide last 4 pay stubs.
- If you are self-employed, please provide a complete copy of last year's filed Income Tax Return (including ALL schedules (i.e. for example, Schedule C).

*Please note we will notify physicians who are part of the Franklin Medical Group of your eligibility.

Appendix B

| 2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA | |
|---|---|
| **Persons in family/household** | **Poverty guideline** |
| For families/households with more than 8 persons, add $4,160 for each additional person. | |
| 1 | $11,770 |
| 2 | 15,930 |
| 3 | 20,090 |
| 4 | 24,250 |
| 5 | 28,410 |
| 6 | 32,570 |
| 7 | 36,730 |
| 8 | 40,890 |

Appendix C

# Sliding Scale Discount Guidelines

1. Less than 200% FPL - 100%
2. 200% – 400% FPL - 65%
3. Greater than 400% - 40%

# APPENDIX D: PARAGON ADJUSTMENT CODES

| TYPE | CODE | DESCRIPTION | Charity or Free Care |
|---|---|---|---|
| A | 48820 | REDUCTION TO COST IP SELF PAY | Charity |
| A | 48830 | REDUCTION TO COST OP SELF PAY | Charity |
| A | 48840 | FREE SERVICE IP SELF PAY | Charity |
| A | 48853 | FREE SERVICE OP SELF PAY | Charity |

# EXHIBIT S5

Subject: **Self Pay Collection Policy**

Effective Date: 5/1/05

Revised 02/01/13

Replaces: NEW

## POLICY

It is the policy of St. Mary's Hospital (SMH) that personnel will review outstanding accounts on a daily basis for timeliness of payment, and that personnel will conduct their collection activity and contact with individual patients with professionalism, courtesy and fairness.

## PURPOSE

1. To ensure that policies and procedures exist for the timely and fair collection of all patient balances.

## PROCEDURE

1. Admission:

All self-pay patients are interviewed by a financial counselor at the point of service. The Financial Counselor will determine if:

- The patient has any insurances that may have been overlooked;
- There is any third-party liability;
- The patient may be eligible for financial assistance, including but not limited to: Medicaid; HUSKY; a Free-Bed fund; and Charity Care;
- Accounts that are determined to be presumptively eligible for any state assistance will be moved from Self-Pay (SFPY) financial class to Welfare Pending (WLFP) financial class.
- Whenever is it determined that the patient qualifies for Charity Care, Financial Counselor will adjust the balance by the appropriate amount, and any resulting balance will become the patient's responsibility.
- If patient is deemed liable for any balance, a deposit will be requested.
- If charity care determination cannot be made, at the point of service, a deposit equal to 50% of the estimated charges will be required prior to any elective procedure.

In the event that a Financial Counselor is not available at the time of admission, they will attempt to contact patients after reviewing their admission record. Financial Counselors will attempt to visit with the patient if they are still in-house; otherwise they will call the patient's home after the patient is discharged.

2. Collection Follow-Up

A. Statements are sent to patients and/or guarantors who have outstanding balances. The timing and frequency of these statements, for both patients with a monthly payment

arrangement and those without, are based upon the statement table/schedule set up in Paragon.

- All accounts that are registered as SFPY will be transferred to Financial Health Strategies (FHS) for follow –up. SMH has contracted with FHS to operate as our Business Office for self-pay accounts. Accounts will be transferred on a daily basis. (see PARPROC for transferring procedures)
- If we get a letter from a patient quoting the Fair Debt Collection Practices Act, 15 USC 1692c, 805(c):

  (c) Ceasing Communications, "If a consumer notifies a debt collector in writing that the consumer refuses to pay a debt or that the consumer wishes the debt collector to cease further communication with the consumer, the debt collector shall not communicate further with the consumer with respect to such debt..."

  We will notify FHS to:

  1. Stop all activity on the account.
  2. Return the account to SMH and SHM staff will refer the account to our collection agency, with a copy of the letter.

  The collection agency is expected to:

  1. Send the validation notice, to the consumer, stating that a new collector is involved.
  2. Then cease all activity and refer the account to their attorney for suit.

B. Accounts will be manually transferred to a bad debt status if one or all of the following has occurred:

- Account has been returned from FHS as part of their “Return File” marked uncollectible. FHS is required to return all accounts that have reached the timeframe of 90 days, with no payments made in the last 45 days.
- Mail is returned stamped “Moved No forwarding Address” and the account is noted as such in the system;
- There is a system note listed in the follow-up history that the third message level on the monthly statement has been mailed;
- No adequate payment has been made in the last thirty (30) days and the patient is not on a payment plan. Adequate is defined as an amount representing 10% or less of the previous balance due.

C. All attorneys representing patients in liability cases are contacted. If we are assured that the case will be settled within 120 days, the account will not be transferred to bad debt. If the settlement date requirement cannot be satisfied, the account is placed with the TCORS (Tobin, Carberry, O’Malley, Riley& Selinger) law firm so that the hospital’s interest can be protected (see TCORS procedures).

3. Bad Debts:

- Accounts are manually transferred from an active (AR) status to a bad debt status by collection personnel;

- Bad debt files are turned over weekly to a collection agency or collection attorney via electronic transfer on a weekly basis;
- Bad debts may be determined at any time during the life of the account;
- Collection personnel may make a determination to turn over an account to a collection agency at any time during the collection process;
- All accounts with a balance due AFTER a Medicare payment has been received MUST have received a minimum of four (4) patient statements over a period of greater than 120 days, and have NOT had a payment posted to the account within the last 120 days before it can be transferred to bad debt.
- Bad debt accounts for Medicare patients must be sent under a separate file to the collection agencies.

4. Settlements:

- FHS Collectors have been given the authority make settlements on accounts that are considered "reasonable". SMH management reserves the right to withdraw this authority at any time.
- SMH Customer Service personnel may offer attorneys representing patients a 5% discount for payment within thirty (30) days, provided the attorney agrees in writing to accept these terms and to discount their fees by the same amount. Any amount exceeding 5% must be approved by management.
- Occasionally, management will authorize collection personnel to offer higher discounts to patients that have previously agreed to payment plans that have had an outstanding balance for more than three (3) years in an effort to settle the account.

5. Collection Agencies:

- Accounts that are sent to bad debt will be assigned to one (1) of the two (2) agencies currently contracted with St. Mary's.
- Account are assigned based on the following Alpha categories:
  I. A - L - American Adjustment Bureau
  II. M – Z - Parallon
- Accounts can be withdrawn from the agencies at any time (see procedure for "removal of account from bad debt").
- If an account has been turned over to the collection agency for a period greater than fourteen (14) days, any request for payment arrangement or settlement must be forward to the agency.
- Collection agencies are required to returned "uncollectible accounts" that are aged greater than 150 days from the date they were transferred.
- All accounts that are returned from the agencies as uncollectible are to be written off to the following codes**: 48903 – Agency Uncollectible**
  **48913 – Agency Uncollectible Medicare**

6. St. Mary's Policy for Attachment of Wages & Properties

St. Mary's does not have a written agreement with any of the Collection Agencies, regarding the procedures they must follow for attachment of wages and properties. According to Outsource Group, they follow a generally accepted policy for all clients. This is a summary of their established policy:

- Account received.

- Initial dunning notice issued within 24 hours of placement.
- Phone attempt made to contact patient.
- If contact is made, the following may occur:
    1. If patient is unable to pay (unemployed, no assets, etc) the account is returned or if permission is granted by SMH, it is maintained for later follow up.
    2. If patient is bankrupt, account is closed and returned.
    3. If patient disputes charges, collection activity is suspended and proof requested from the hospital.
    4. If patient request financial assistance, collection activity is suspended and the patient is either mailed a SMH financial assistance application or given phone number to contact SMH for an application. If application is mailed to patient, SMH customer service staff is notified by phone and they are requested to document the account.
    5. If settlement is offered, authorization is sought from SMH.

- If all efforts to contact patient fail, or if patient refuses to pay, and it is verified that patient has income or assets that could be used to satisfy charges, the following steps are taken:
    1. Documentation is made of all collection efforts, including: efforts to contact patient, letters sent, income & asset verified, etc.
    2. Authorization is sought from SMH to proceed with litigation.
    3. After authorization is received, the account, along with the documentation, is forwarded to Attorney's Nathanson & Cipriano; P.O. Box 5516; Hamden, Ct 06518.

Summary of Litigation Procedure Followed by Nathanson & Cipriano's Office:

- Account received and documented. File created.
- First demand letter sent to patient.
- File reviewed and approved by Attorney.
- Signed letter sent to patient and Affidavit of Debt sent to collection agency.
- File is designated for either small claims or civil writ.
- Writ is reviewed and signed by Attorney.
- Writ sent to court; summon and complaint sent to State Marshal for service.
- If patient files an answer, case is scheduled for hearing. SMH is notified of hearing and a representative sent to the hearing.
- If no answer is filed a default judgment is entered.
- Once judgment is received, a payment plan is established in accordance with the court order.
- If patient defaults on payment plan and there is verification of employment, application is made for wage execution.
- If there is verified real estate, a judgment lien is filed. NO FORECLOSURE IS DONE ON ANY JUDGMENT LIEN.

# EXHIBIT S5

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 10/01, 2013, and ending 09/30, 20 14

**B** Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Terminated ☐ Amended return ☐ Application pending

**C** Name of organization: ST. MARY'S HOSPITAL, INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address): 56 FRANKLIN STREET | Room/suite

City or town, state or province, country, and ZIP or foreign postal code: WATERBURY, CT 06706-1281

**D** Employer identification number: 06-0646844

**E** Telephone number: (203) 709-6111

**G** Gross receipts $ 279,523,406.

**F** Name and address of principal officer: CHAD WABLE
56 FRANKLIN STREET WATERBURY, CT 06706-1281

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

**I** Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

**J** Website: ▶ WWW.STMH.ORG

H(c) Group exemption number ▶ 0928

**K** Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

**L** Year of formation: 1907 **M** State of legal domicile: CT

## Part I Summary

**Activities & Governance**

1 Briefly describe the organization's mission or most significant activities: SAINT MARY'S HOSPITAL PROVIDES EXCELLENT HEALTHCARE IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY.

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 | 20. |
| 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 16. |
| 5 | Total number of individuals employed in calendar year 2013 (Part V, line 2a) | 5 | 1,886. |
| 6 | Total number of volunteers (estimate if necessary) | 6 | 171. |
| 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 955,477. |
| b | Net unrelated business taxable income from Form 990-T, line 34 | 7b | 403,825. |

| | | | Prior Year | Current Year |
|---|---|---|---|---|
| Revenue | 8 | Contributions and grants (Part VIII, line 1h) | 732,890. | 1,607,114. |
| | 9 | Program service revenue (Part VIII, line 2g) | 239,560,411. | 248,807,341. |
| | 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 4,137,914. | 4,893,950. |
| | 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 5,876,260. | 7,471,863. |
| | 12 | Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 250,307,475. | 262,780,268. |
| Expenses | 13 | Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 7,850. | 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) | 111,272,363. | 109,911,511. |
| | 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| | b | Total fundraising expenses (Part IX, column (D), line 25) ▶ 0 | | |
| | 17 | Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | 120,659,761. | 127,849,647. |
| | 18 | Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 231,939,974. | 237,761,158. |
| | 19 | Revenue less expenses. Subtract line 18 from line 12 | 18,367,501. | 25,019,110. |
| | | | **Beginning of Current Year** | **End of Year** |
| Net Assets or Fund Balances | 20 | Total assets (Part X, line 16) | 187,262,087. | 187,153,109. |
| | 21 | Total liabilities (Part X, line 26) | 137,565,692. | 140,389,197. |
| | 22 | Net assets or fund balances. Subtract line 21 from line 20 | 49,696,395. | 46,763,912. |

## 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 8/14/15

▶ Chad Wable President & CEO
Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN |
|---|---|---|---|---|
| MARY-EVELYN ANTONETTI | Mary Evelyn Antonetti | 8/13/2015 | | P00431862 |

Firm's name ▶ KPMG LLP — Firm's EIN ▶ 13-5565207

Firm's address ▶ ONE FINANCIAL PLAZA HARTFORD, CT 06103-2608 — Phone no. 860-522-3200

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2013)

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Public Disclosure Copy

# Form 990 — Return of Organization Exempt From Income Tax

Department of the Treasury
Internal Revenue Service

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 10/01, 2013, and ending 09/30, 20 14

**B** Check if applicable: [ ] Address change [ ] Name change [ ] Initial return [ ] Terminated [ ] Amended return [ ] Application pending

**C** Name of organization: ST. MARY'S HOSPITAL, INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address): 56 FRANKLIN STREET — Room/suite

City or town, state or province, country, and ZIP or foreign postal code: WATERBURY, CT 06706-1281

**D** Employer identification number: 06-0646844

**E** Telephone number: (203) 709-6111

**G** Gross receipts $ 279,523,406.

**F** Name and address of principal officer: CHAD WABLE
56 FRANKLIN STREET WATERBURY, CT 06706-1281

H(a) Is this a group return for subordinates? [ ] Yes [X] No

H(b) Are all subordinates included? [ ] Yes [ ] No
If "No," attach a list. (see instructions)

**I** Tax-exempt status: [X] 501(c)(3) [ ] 501(c) ( ) ◀ (insert no.) [ ] 4947(a)(1) or [ ] 527

**J** Website: ▶ WWW.STMH.ORG

H(c) Group exemption number ▶ 0928

**K** Form of organization: [X] Corporation [ ] Trust [ ] Association [ ] Other ▶

**L** Year of formation: 1907 **M** State of legal domicile: CT

## Part I Summary

**Activities & Governance**

1 Briefly describe the organization's mission or most significant activities: SAINT MARY'S HOSPITAL PROVIDES EXCELLENT HEALTHCARE IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY.

2 Check this box ▶ [ ] if the organization discontinued its operations or disposed of more than 25% of its net assets.

| | | | |
|---|---|---|---|
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| Expenses | 13 | Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 7,850. | 0 |
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| | 15 | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) | 111,272,363. | 109,911,511. |
| | 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| | b | Total fundraising expenses (Part IX, column (D), line 25) ▶ 0 | | |
| | 17 | Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | 120,659,761. | 127,849,647. |
| | 18 | Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 231,939,974. | 237,761,158. |
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| | | | **Beginning of Current Year** | **End of Year** |
| Net Assets or Fund Balances | 20 | Total assets (Part X, line 16) | 187,262,087. | 187,153,109. |
| | 21 | Total liabilities (Part X, line 26) | 137,565,692. | 140,389,197. |
| | 22 | Net assets or fund balances. Subtract line 21 from line 20 | 49,696,395. | 46,763,912. |

COPY FOR PUBLIC INSPECTION

## 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

▶ Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check [ ] if self-employed | PTIN |
|---|---|---|---|---|
| MARY-EVELYN ANTONETTI | Mary-Evelyn Antonetti | 8/13/2015 | | P00431862 |

Firm's name ▶ KPMG LLP — Firm's EIN ▶ 13-5565207

Firm's address ▶ ONE FINANCIAL PLAZA HARTFORD, CT 06103-2608 — Phone no. 860-522-3200

May the IRS discuss this return with the preparer shown above? (see instructions) [X] Yes [ ] No

For Paperwork Reduction Act Notice, see the separate instructions. Form 990 (2013)

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**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:
SAINT MARY'S HEALTH SYSTEM PROVIDES EXCELLENT HEALTHCARE IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY. SEE SCHEDULE O.

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 [X] 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 [X] 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 $ 91,381,523. including grants of $ _____) (Revenue $ 139,144,254. )
INPATIENT SAINT MARY'S REMAINS COMMITTED TO PROVIDING THE HIGHEST QUALITY CARE FOR OUR PATIENTS. THE HOSPITAL PROVIDED INPATIENT TREATMENT FOR 11,698 INPATIENTS IN 2014. PLEASE SEE SCHEDULE O FOR ADDITIONAL INFORMATION ABOUT SAINT MARY'S INPATIENT SERVICES PROGRAM.

4b (Code: _____) (Expenses $ 88,486,574. including grants of $ _____) (Revenue $ 114,931,820. )
OUTPATIENT SAINT MARY'S HEALTH SYSTEM EXTENDS FROM WATERBURY TO WOLCOTT, NAUGATUCK, SOUTHBURY AND PROSPECT. IN 2014, 216,818 PATIENTS CHOSE SAINT MARY'S FOR OUTPATIENT CARE. PLEASE SEE SCHEDULE O FOR ADDITIONAL INFORMATION ABOUT THE OUTPATIENT SERVICES PROGRAM.

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 ▶ 179,868,097.

**Part IV Checklist of Required Schedules**

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A* | 1 | X | |
| 2 | Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)? | 2 | X | |
| 3 | Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I* | 3 | | X |
| 4 | **Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II* | 4 | X | |
| 5 | Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III* | 5 | | X |
| 6 | Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I* | 6 | | X |
| 7 | Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II* | 7 | | X |
| 8 | Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III* | 8 | | X |
| 9 | Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV* | 9 | | X |
| 10 | Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V* | 10 | X | |
| 11 | If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable. | | | |
| a | Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI* | 11a | X | |
| b | Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII* | 11b | X | |
| c | Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII* | 11c | | X |
| d | Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX* | 11d | | X |
| e | Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X* | 11e | X | |
| f | Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X* | 11f | X | |
| 12a | Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII* | 12a | | X |
| b | Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional* | 12b | X | |
| 13 | Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E* | 13 | | X |
| 14a | Did the organization maintain an office, employees, or agents outside of the United States? | 14a | | X |
| b | Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV* | 14b | | X |
| 15 | Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV* | 15 | | X |
| 16 | Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV* | 16 | | X |
| 17 | Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)* | 17 | | X |
| 18 | Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II* | 18 | | X |
| 19 | Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III* | 19 | | X |
| 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 | |
| 24 a | Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a* | 24a | | X |
| b | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | | |
| c | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | 24c | | |
| d | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | | |
| 25 a | **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 payable 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 | |
| 35 a | 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 | 167 | | |
| 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 | 1,886 | | | |
| 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 | | |
| 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 20 | | | |
| | 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 16 | | | |
| 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 ▶ CT,

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 [X] Upon request [ ] Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ KYLE JURCZYK 56 FRANKLIN STREET WATERBURY, CT 06706-1281 203-709-6111

**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 . . . . . [X]

**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 dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee): Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| (1) CHAD WABLE | 40.00 | | | | | | | | | |
| PRESIDENT AND CEO | 10.00 | X | | X | | | | 755,516. | 0 | 186,789. |
| (2) JOSEPH CARLSON, II | 4.00 | | | | | | | | | |
| TREASURER | 4.00 | X | | X | | | | 0 | 0 | 0 |
| (3) REV. MONSIGNOR JAMES COLEMAN | 1.00 | | | | | | | | | |
| VICE CHAIRMAN | 4.00 | X | | X | | | | 0 | 0 | 0 |
| (4) STEPHEN R. GRIFFIN, ESQ. | 4.00 | | | | | | | | | |
| SECRETARY | 4.00 | X | | X | | | | 0 | 0 | 0 |
| (5) JEROME SUGAR, M.D. | 4.00 | | | | | | | | | |
| CHIEF OF STAFF THRU 12/31/2013 | 3.00 | X | | X | | | | 69,625. | 0 | 0 |
| (6) S. MARK ALBINI, M.D. | 1.00 | | | | | | | | | |
| DIRECTOR | 2.00 | X | | | | | | 49,000. | 0 | 0 |
| (7) GARRETT CASEY | 4.00 | | | | | | | | | |
| DIRECTOR | 2.00 | X | | | | | | 0 | 0 | 0 |
| (8) SISTER DOLORES LAHR | 2.00 | | | | | | | | | |
| DIRECTOR | 2.00 | X | | | | | | 0 | 0 | 0 |
| (9) JOSEPH MENGACCI, ESQ. | 4.00 | | | | | | | | | |
| DIRECTOR | 2.00 | X | | | | | | 0 | 0 | 0 |
| (10) WILLIAM MORRIS | 1.00 | | | | | | | | | |
| DIRECTOR THRU 12/31/2013 | 4.00 | X | | | | | | 0 | 0 | 0 |
| (11) MICHAEL O'BRIEN | 1.00 | | | | | | | | | |
| DIRECTOR | 1.00 | X | | | | | | 0 | 0 | 0 |
| (12) DAVID ROBINSON | 2.00 | | | | | | | | | |
| DIRECTOR THRU 12/31/2013 | 3.00 | X | | | | | | 0 | 0 | 0 |
| (13) ROBERT ROSCOE | 1.00 | | | | | | | | | |
| DIRECTOR | 1.00 | X | | | | | | 0 | 0 | 0 |
| (14) JAMES C. SMITH | 4.00 | | | | | | | | | |
| DIRECTOR | 1.00 | X | | | | | | 0 | 0 | 0 |

**Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee): Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| (15) CHRISTINE SULLIVAN, ESQ. | 1.00 | | | | | | | | | |
| DIRECTOR | 4.00 | X | | | | | | 0 | 0 | 0 |
| (16) JAMES UBERTI, M.D. | 1.00 | | | | | | | | | |
| DIRECTOR | 40.00 | X | | | | | | 0 | 205,088. | 10,027. |
| (17) THE HONORABLE LINDA WIHBEY | 1.00 | | | | | | | | | |
| DIRECTOR (THRU 12/31/2013) | 4.00 | X | | | | | | 0 | 0 | 0 |
| (18) MICHAEL KARNASIEWICZ, M.D. | 1.00 | | | | | | | | | |
| DIRECTOR | 1.00 | X | | | | | | 0 | 0 | 0 |
| (19) ROBERT MAZAIKA | 2.00 | | | | | | | | | |
| CHAIRMAN (SINCE 1/1/2014) | 2.00 | X | | X | | | | 0 | 0 | 0 |
| (20) ERIC ALBERT | 1.00 | | | | | | | | | |
| DIRECTOR (SINCE 1/1/2014) | 1.00 | X | | | | | | 0 | 0 | 0 |
| (21) ROBERT GUMBARDO, M.D. | 4.00 | | | | | | | | | |
| DIRECTOR (SINCE 1/1/2014) | 2.00 | X | | | | | | 0 | 0 | 0 |
| (22) ANGELA MATTIE | 1.00 | | | | | | | | | |
| DIRECTOR (SINCE 1/1/2014) | 1.00 | X | | | | | | 0 | 0 | 0 |
| (23) RICHARD PUGH | 1.00 | | | | | | | | | |
| DIRECTOR (SINCE 1/1/2014) | 1.00 | X | | | | | | 0 | 0 | 0 |
| (24) FELIX RODRIQUEZ | 1.00 | | | | | | | | | |
| DIRECTOR (SINCE 1/1/2014) | 1.00 | X | | | | | | 0 | 0 | 0 |
| (25) LAURA ST. JOHN | 1.00 | | | | | | | | | |
| DIRECTOR (SINCE 1/1/2014) | 1.00 | X | | | | | | 0 | 0 | 0 |
| **1b Sub-total** ▶ | | | | | | | | 874,141. | 0 | 186,789. |
| **c Total from continuation sheets to Part VII, Section A** ▶ | | | | | | | | 1,933,407. | 644,871. | 320,237. |
| **d Total (add lines 1b and 1c)** ▶ | | | | | | | | 2,807,548. | 644,871. | 507,026. |

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 ▶ 93

| | | 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 |
|---|---|---|
| ATTACHMENT 1 | | |
| | | |
| | | |
| | | |
| | | |

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 64

**Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee): Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| (26) RALPH BECKER | 40.00 | | | | | | | | | |
| CFO (SINCE 1/27/2014) | | | | X | | | | 0 | 0 | 0 |
| (27) CHARLES FINN | 40.00 | | | | | | | | | |
| COO (SINCE 1/13/2014) | | | | X | | | | 0 | 0 | 0 |
| (28) MICHAEL NOVAK | 40.00 | | | | | | | | | |
| VP OPERATIONS | | | | | X | | | 289,312. | 0 | 39,546. |
| (29) M. CLARK KEARNEY | 40.00 | | | | | | | | | |
| VP HUMAN RESOURCES | | | | | | X | | 249,369. | 0 | 36,662. |
| (30) JOSEPH CONNOLLY | 40.00 | | | | | | | | | |
| CHIEF MARKETING OFFICER | | | | | | X | | 185,357. | 0 | 37,070. |
| (31) STEPHEN SCHNEIDER, MD | 40.00 | | | | | | | | | |
| CMO | 10.00 | | | | | X | | 0 | 439,783. | 55,648. |
| (32) GREG BULLER, MD | 40.00 | | | | | | | | | |
| CHAIRMAN, DEPT. OF MEDICINE | | | | | | X | | 255,560. | 0 | 18,765. |
| (33) ELIZABETH BOZZUTO | 40.00 | | | | | | | | | |
| VP SURGICAL SERVICES | | | | | | X | | 290,102. | 0 | 47,790. |
| (34) ROBERT RILEY, CFO | | | | | | | | | | |
| CFO (FORMER) | | | | | | | X | 226,417. | 0 | 32,847. |
| (35) SANDRA ROOSA | | | | | | | | | | |
| VP PATIENT SVC | | | | | | | X | 221,872. | 0 | 36,757. |
| (36) CAROLYN ORRELL | | | | | | | | | | |
| CIO (FORMER) | | | | | | | X | 215,418. | 0 | 5,125. |
| **1b Sub-total** ▶ | | | | | | | | | | |
| **c Total from continuation sheets to Part VII, Section A** ▶ | | | | | | | | | | |
| **d Total (add lines 1b and 1c)** ▶ | | | | | | | | | | |

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 ▶ 93

| | | Yes | No |
|---|---|---|---|
| 3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual* | 3 | X | |
| 4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual* | 4 | X | |
| 5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person* | 5 | | X |

**Section B. Independent Contractors**

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶

**Part VIII Statement of Revenue**

Check if Schedule O contains a response or note to any line in this Part VIII . . . . . X

| | | | | (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 | 75,420. | | | |
| | e | Government grants (contributions) | 1e | 531,694. | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 1,000,000. | | | |
| | g | Noncash contributions included in lines 1a-1f: $ | | | | | |
| | h | Total. Add lines 1a-1f ▶ | | 1,607,114. | | | |
| Program Service Revenue | | | Business Code | | | | |
| | 2a | NET PATIENT REVENUE | 900099 | 248,807,341. | 248,807,341. | | |
| | b | | | | | | |
| | c | | | | | | |
| | d | | | | | | |
| | e | | | | | | |
| | f | All other program service revenue | | | | | |
| | g | Total. Add lines 2a-2f ▶ | | 248,807,341. | | | |
| Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) ATTACHMENT 2 ▶ | | 3,767,233. | | -4,499. | 3,771,732. |
| | 4 | Income from investment of tax-exempt bond proceeds ▶ | | 0 | | | |
| | 5 | Royalties ▶ | | 0 | | | |
| | | | (i) Real | (ii) Personal | | | |
| | 6a | Gross rents | 1,243,154. | | | | |
| | b | Less: rental expenses | | | | | |
| | c | Rental income or (loss) | 1,243,154. | | | | |
| | d | Net rental income or (loss) ▶ | | 1,243,154. | | | 1,243,154. |
| | | | (i) Securities | (ii) Other | | | |
| | 7a | Gross amount from sales of assets other than inventory | 17,869,855. | 1,172,414. | | | |
| | b | Less: cost or other basis and sales expenses | 16,697,441. | 45,697. | | | |
| | c | Gain or (loss) | 1,172,414. | 1,126,717. | | | |
| | d | Net gain or (loss) ▶ | | 1,126,717. | | | 1,126,717. |
| | 8a | Gross income from fundraising events (not including $ ____ of contributions reported on line 1c). See Part IV, line 18 a | | | | | |
| | b | Less: direct expenses b | | | | | |
| | c | Net income or (loss) from fundraising events ▶ | | 0 | | | |
| | 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 ▶ | | 0 | | | |
| | 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 ▶ | | 0 | | | |
| | | Miscellaneous Revenue | Business Code | | | | |
| | 11a | CAFETERIA & DIETARY | 900099 | 1,170,616. | 1,170,616. | | |
| | b | MEANINGFUL USE | 900099 | 2,840,267. | 2,840,267. | | |
| | c | PHYSICIAN MALPRACTICE PREMIUMS | | 577,645. | | 577,645. | |
| | d | All other revenue | 812930 | 1,640,181. | 1,257,850. | 382,331. | |
| | e | Total. Add lines 11a-11d ▶ | | 6,228,709. | | | |
| | 12 | Total revenue. See instructions ▶ | | 262,780,268. | 254,076,074. | 955,477. | 6,141,603. |

**Part IX Statement of Functional Expenses**

*Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).*

Check if Schedule O contains a response or note to any line in this Part IX . . . . . ☐

| *Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.* | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|---|---|---|---|
| 1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 | 0 | | | |
| 2 Grants and other assistance to individuals in the United States. See Part IV, line 22 | 0 | | | |
| 3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16 | 0 | | | |
| 4 Benefits paid to or for members | 0 | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 3,571,513. | 1,785,756. | 1,785,757. | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0 | | | |
| 7 Other salaries and wages | 82,313,271. | 70,130,907. | 12,182,364. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 7,194,895. | 6,024,732. | 1,170,163. | |
| 9 Other employee benefits | 10,504,369. | 8,795,960. | 1,708,409. | |
| 10 Payroll taxes | 6,327,463. | 5,298,378. | 1,029,085. | |
| 11 Fees for services (non-employees): | | | | |
| a Management | 0 | | | |
| b Legal | 1,588,789. | 397,197. | 1,191,592. | |
| c Accounting | 270,562. | 67,640. | 202,922. | |
| d Lobbying | 145,704. | | 145,704. | |
| e Professional fundraising services. See Part IV, line 17 | 0 | | | |
| f Investment management fees | 0 | | | |
| g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) | 34,741,140. | 21,286,460. | 13,454,680. | |
| 12 Advertising and promotion | 568,970. | 426,727. | 142,243. | |
| 13 Office expenses | 9,330,115. | 6,345,673. | 2,984,442. | |
| 14 Information technology | 0 | | | |
| 15 Royalties | 0 | | | |
| 16 Occupancy | 13,337,712. | 7,924,689. | 5,413,023. | |
| 17 Travel | 203,873. | 122,324. | 81,549. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | | | |
| 19 Conferences, conventions, and meetings | 340,398. | 204,239. | 136,159. | |
| 20 Interest | 1,404,558. | 351,139. | 1,053,419. | |
| 21 Payments to affiliates | 0 | | | |
| 22 Depreciation, depletion, and amortization | 9,887,837. | 2,471,959. | 7,415,878. | |
| 23 Insurance | 5,478,532. | 3,287,119. | 2,191,413. | |
| 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 SUPPLIES | 35,048,979. | 31,544,081. | 3,504,898. | |
| b BAD DEBT | 10,078,145. | 10,078,145. | | |
| c CONSULTING | 2,283,360. | 1,370,016. | 913,344. | |
| d DUES AND SUBSCRIPTIONS | 852,330. | 639,247. | 213,083. | |
| e All other expenses | 2,288,643. | 1,315,709. | 972,934. | |
| 25 Total functional expenses. Add lines 1 through 24e | 237,761,158. | 179,868,097. | 57,893,061. | |
| 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) | 0 | | | |

**Part X Balance Sheet**

Check if Schedule O contains a response or note to any line in this Part X . . . . . [X]

| | | | (A) Beginning of year | | (B) End of year |
|---|---|---|---|---|---|
| Assets | 1 | Cash - non-interest-bearing | 28,153,440. | 1 | 24,610,433. |
| | 2 | Savings and temporary cash investments | 28,942. | 2 | 16,948. |
| | 3 | Pledges and grants receivable, net | 31,774. | 3 | 95,342. |
| | 4 | Accounts receivable, net | 28,776,370. | 4 | 26,815,465. |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | 0 | 5 | 0 |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L | 0 | 6 | 0 |
| | 7 | Notes and loans receivable, net | -260,186. | 7 | -121,001. |
| | 8 | Inventories for sale or use | 2,220,053. | 8 | 3,644,672. |
| | 9 | Prepaid expenses and deferred charges | 1,914,476. | 9 | 2,489,313. |
| | 10a | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a 188,967,766. | | | |
| | b | Less: accumulated depreciation — 10b 129,200,168. | 61,043,215. | 10c | 59,767,598. |
| | 11 | Investments - publicly traded securities ATCH 3 | 18,505,914. | 11 | 20,802,742. |
| | 12 | Investments - other securities. See Part IV, line 11 | 46,720,286. | 12 | 48,928,064. |
| | 13 | Investments - program-related. See Part IV, line 11 | 0 | 13 | 0 |
| | 14 | Intangible assets | 0 | 14 | 0 |
| | 15 | Other assets. See Part IV, line 11 | 127,803. | 15 | 103,533. |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | 187,262,087. | 16 | 187,153,109. |
| Liabilities | 17 | Accounts payable and accrued expenses | 37,596,331. | 17 | 34,904,423. |
| | 18 | Grants payable | 0 | 18 | 0 |
| | 19 | Deferred revenue | 0 | 19 | 0 |
| | 20 | Tax-exempt bond liabilities | 21,332,784. | 20 | 19,509,799. |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | 0 | 21 | 0 |
| | 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 | 0 | 22 | 0 |
| | 23 | Secured mortgages and notes payable to unrelated third parties | 0 | 23 | 0 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | 0 | 24 | 0 |
| | 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 | 78,636,577. | 25 | 85,974,975. |
| | 26 | **Total liabilities.** Add lines 17 through 25 | 137,565,692. | 26 | 140,389,197. |
| Net Assets or Fund Balances | | **Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.** | | | |
| | 27 | Unrestricted net assets | 31,172,558. | 27 | 27,668,208. |
| | 28 | Temporarily restricted net assets | 2,269,137. | 28 | 2,414,574. |
| | 29 | Permanently restricted net assets | 16,254,700. | 29 | 16,681,130. |
| | | **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 | 49,696,395. | 33 | 46,763,912. |
| | 34 | Total liabilities and net assets/fund balances | 187,262,087. | 34 | 187,153,109. |

**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 | 262,780,268. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 237,761,158. |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 25,019,110. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 49,696,395. |
| 5 | Net unrealized gains (losses) on investments | 5 | -527,000. |
| 6 | Donated services and use of facilities | 6 | 0 |
| 7 | Investment expenses | 7 | 0 |
| 8 | Prior period adjustments | 8 | 0 |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -27,424,593. |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 46,763,912. |

**Part XII Financial Statements and Reporting**

Check if Schedule O contains a response or note to any line in this Part XII . . . . . [ ]

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Accounting method used to prepare the Form 990: [ ] Cash [X] 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 [X] 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 | X | |

**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**
ST. MARY'S HOSPITAL, INC.

**Employer identification number**
06-0646844

**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 [X] 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? Yes | No | (v) Did you notify the organization in col. (i) of your support? Yes | No | (vi) Is the organization in col. (i) organized in the U.S.? Yes | No | (vii) Amount of monetary support |
|---|---|---|---|---|---|---|---|---|---|
| (A) | | | | | | | | | |
| (B) | | | | | | | | | |
| (C) | | | | | | | | | |
| (D) | | | | | | | | | |
| (E) | | | | | | | | | |
| Total | | | | | | | | | |

**For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.**

**Schedule A (Form 990 or 990-EZ) 2013**

JSA
3E1210 1.000

**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 |
|---|---|
| ST. MARY'S HOSPITAL, INC. | 06-0646844 |

**Organization type** (check one):

| **Filers of:** | **Section:** |
|---|---|
| Form 990 or 990-EZ | [X] 501(c)( 03 ) (enter number) organization |
| | [ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation |
| | [ ] 527 political organization |
| Form 990-PF | [ ] 501(c)(3) exempt private foundation |
| | [ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation |
| | [ ] 501(c)(3) taxable private foundation |

Check if your organization is covered by the **General Rule** or a **Special Rule.**
**Note.** Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

**General Rule**

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $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).

**For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF.**

Name of organization ST. MARY'S HOSPITAL, INC.

Employer identification number 06-0646844

**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 | | $ 80,420. | Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.) |
| 2 | | $ 191,245. | Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.) |
| 3 | | $ 340,449. | Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.) |
| 4 | | $ 1,000,000. | 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.) |

Name of organization ST. MARY'S HOSPITAL, INC.

Employer identification number 06-0646844

**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 |
|---|---|---|---|
| | | $ | |

| (a) No. from Part I | (b) Description of noncash property given | (c) FMV (or estimate) (see instructions) | (d) Date received |
|---|---|---|---|
| | | $ | |

| (a) No. from Part I | (b) Description of noncash property given | (c) FMV (or estimate) (see instructions) | (d) Date received |
|---|---|---|---|
| | | $ | |

| (a) No. from Part I | (b) Description of noncash property given | (c) FMV (or estimate) (see instructions) | (d) Date received |
|---|---|---|---|
| | | $ | |

| (a) No. from Part I | (b) Description of noncash property given | (c) FMV (or estimate) (see instructions) | (d) Date received |
|---|---|---|---|
| | | $ | |

| (a) No. from Part I | (b) Description of noncash property given | (c) FMV (or estimate) (see instructions) | (d) Date received |
|---|---|---|---|
| | | $ | |

Name of organization ST. MARY'S HOSPITAL, INC.

Employer identification number 06-0646844

**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. See instructions.) ▶ $

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 |
|---|---|
| ST. MARY'S HOSPITAL, INC. | 06-0646844 |

## 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-. |
|---|---|---|---|---|---|
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |

**For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.**

**Schedule C (Form 990 or 990-EZ) 2013**

JSA
3E1264 1.000

**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. | | |
| 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- | | |

| 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. |

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 | |
| 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 | | 145,704. |
| j Total. Add lines 1c through 1i | | | 145,704. |
| 2 a 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? | | X | |

**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.

SEE PAGE 4

**Part IV Supplemental Information** *(continued)*

SCHEDULE C - PART II-B - LINE 1I

$1,402 - THE CATHOLIC HEALTH ASSOCATION - ANNUAL MEMBERSHIP DUES

$90,000 - LEGAL FEES RELATED TO LOBBYING

$35,802 - CONNECTICUT HOSPITAL ASSOCIATION - PORTION OF MEMBERSHIP DUES EXPENDED ON LOBBYING

$18,500 - COMPENSATION OF CHIEF MARKETING OFFICER ATTRIBUTABLE TO LOBBYING (APPROXIMATELY 10% OF OFFICER TIME SPENT ON LOBBYING ACTIVITIES)

TOTAL OTHER LOBBYING ACTIVITIES: $145,704

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: ST. MARY'S HOSPITAL, INC.
Employer identification number: 06-0646844

## 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)
- ☐ Preservation of an historically important land area
- ☐ Protection of natural habitat
- ☐ Preservation of a certified historic structure
- ☐ Preservation of open space

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 | 16,630,000. | 15,567,000. | 13,783,000. | 14,500,000. | 13,893,000. |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | 1,264,000. | 1,768,000. | 2,426,000. | -64,000. | 1,286,000. |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | 756,000. | 705,000. | 642,000. | 653,000. | 679,000. |
| f Administrative expenses | | | | | |
| g End of year balance | 17,138,000. | 16,630,000. | 15,567,000. | 13,783,000. | 14,500,000. |

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ _____ %

b Permanent endowment ▶ 2.6700 %

c Temporarily restricted endowment ▶ 97.3300 %

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 | | 7,272,019. | | 7,272,019. |
| b Buildings | | 65,301,177. | 48,126,290. | 17,174,887. |
| c Leasehold improvements | | | | |
| d Equipment | | 115,755,461. | 80,754,037. | 35,001,424. |
| e Other | | 639,108. | 319,840. | 319,268. |
| **Total.** Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* . . . . . ▶ | | | | 59,767,598. |

**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 | 5,181,551. | ATTACHMENT 1 |
| (3) Other | | |
| (A) DONOR & HELD IN TRUST BY OTHER | 15,696,295. | FMV |
| (B) DEBT SERVICE FUND | 4,321,505. | FMV |
| (C) MISCELLANEOUS FUNDS | 5,613. | FMV |
| (D) INVESTMENTS IN JOINT VENTURES | 23,723,100. | FMV |
| (E) | | |
| (F) | | |
| (G) | | |
| (H) | | |
| Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶ | 48,928,064. | |

**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. *(Column (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) DUE TO REIMBURSEMENT AGENCIES | 782,612. |
| (3) SELF INSURANCE LIABILITY | 3,278,452. |
| (4) PENSION LIABILITY | 72,181,823. |
| (5) OTHER LONG TERM LIABILITIES | 9,463,675. |
| (6) OTHER LONG TERM DEBT (CAPITAL | 268,413. |
| (7) | |
| (8) | |
| (9) | |
| Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶ | 85,974,975. |

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 | |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | | | |
| a | Net unrealized gains on investments | 2a | | | |
| b | Donated services and use of facilities | 2b | | | |
| c | Recoveries of prior year grants | 2c | | | |
| d | Other (Describe in Part XIII.) | 2d | | | |
| e | Add lines 2a through 2d | | | 2e | |
| 3 | Subtract line 2e from line 1 | | | 3 | |
| 4 | Amounts included on Form 990, Part VIII, line 12, but not on line 1: | | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | | | |
| b | Other (Describe in Part XIII.) | 4b | | | |
| c | Add lines 4a and 4b | | | 4c | |
| 5 | Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)* | | | 5 | |

**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 | |
| 2 | Amounts included on line 1 but not on Form 990, Part IX, line 25: | | | | |
| a | Donated services and use of facilities | 2a | | | |
| b | Prior year adjustments | 2b | | | |
| c | Other losses | 2c | | | |
| d | Other (Describe in Part XIII.) | 2d | | | |
| e | Add lines 2a through 2d | | | 2e | |
| 3 | Subtract line 2e from line 1 | | | 3 | |
| 4 | Amounts included on Form 990, Part IX, line 25, but not on line 1: | | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | | | |
| b | Other (Describe in Part XIII.) | 4b | | | |
| c | Add lines 4a and 4b | | | 4c | |
| 5 | Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)* | | | 5 | |

**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.

SEE PAGE 5

**Part XIII Supplemental Information** *(continued)*

PART V, LINE 4

THE INTENDED USE OF THE ENDOWMENT FUNDS IS TO USE THE INCOME GENERATED TO SUPPORT THE MISSION OF THE HOSPITAL. THE HOSPITAL ADOPTED INVESTMENT AND SPENDING POLICIES FOR ENDOWMENT ASSETS THAT ATTEMPT TO PROVIDE A PREDICTABLE STREAM OF FUNDING TO PROGRAMS SUPPORTED BY ITS ENDOWMENT WHILE SEEKING TO MAINTAIN THE PURCHASING POWER OF THE ENDOWMENT ASSETS. THE HOSPITAL FOLLOWS A POLICY OF SPENDING AN AMOUNT THAT APPROXIMATES THE INVESTMENT INCOME EARNED, IN ADDITION TO SPECIFIC PURCHASES OF CAPITAL EQUIPMENT. ACCORDINGLY, THE HOSPITAL EXPECTS ITS SPENDING POLICY WILL ALLOW ITS ENDOWMENT FUNDS TO BE MAINTAINED IN PERPETUITY BY GROWING AT A RATE AT LEAST EQUAL TO THE PLANNED PAYOUTS. ADDITIONAL REAL ENDOWMENT GROWTH WILL BE PROVIDED THROUGH NEW GIFTS AND ANY EXCESS INVESTMENT RETURN.

PART X, LINE 2

THE HOSPITAL IS A TAX-EXEMPT ORGANIZATION AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND IS GENERALLY EXEMPT FROM INCOME TAXES. THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS HAVE BEEN PREPARED ON THE BASIS THAT ITS TAX-EXEMPT STATUS WILL BE MAINTAINED.

THE INDEMNITY COMPANY AND PHYSICIAN PARTNERS ARE DISREGARDED ENTITIES. THE TAX CONSEQUENCES OF THEIR OPERATING RESULTS ARE ASSESSED AT THE MEMBER LEVEL.

THE HOSPITAL RECOGNIZES THE EFFECT OF INCOME TAX POSITIONS ONLY IF THOSE POSITIONS ARE MORE LIKELY THAN NOT OF BEING SUSTAINED. RECOGNIZED INCOME

**Part XIII Supplemental Information** *(continued)*

TAX POSITIONS ARE MEASURED AT THE LARGEST AMOUNT OF BENEFIT THAT IS GREATER THAN FIFTY PERCENT LIKELY TO BE REALIZED UPON SETTLEMENT. CHANGES IN RECOGNITION IN MEASUREMENT ARE REFLECTED IN THE PERIOD IN WHICH THE CHANGE IN JUDGMENT OCCURS. THE HOSPITAL DID NOT RECOGNIZE THE EFFECT OF ANY INCOME TAX POSITIONS IN EITHER 2014 OR 2013.

ATTACHMENT 1

SCHEDULE D, PART VII - INVESTMENTS - CLOSELY HELD EQUITY INTERESTS

| DESCRIPTION | BOOK VALUE | COST OR FMV |
|---|---|---|
| NET INTEREST IN FOUNDATION | 5,181,551. | FMV |
| TOTALS | 5,181,551. | |

Public Disclosure Copy

**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: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

## 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 250.0000 % | 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) | | | 328,346. | | 328,346. | .14 |
| b Medicaid (from Worksheet 3, column a) | | | 68,868,328. | 55,785,133. | 13,083,195. | 5.75 |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 69,196,674. | 55,785,133. | 13,411,541. | 5.89 |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 147,207. | | 147,207. | .06 |
| f Health professions education (from Worksheet 5) | | | 19,733,222. | 17,074,901. | 2,658,321. | 1.17 |
| g Subsidized health services (from Worksheet 6) | | | 3,622,131. | 2,236,001. | 1,386,130. | .61 |
| h Research (from Worksheet 7) | | | 165,239. | | 165,239. | .07 |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 70,911. | | 70,911. | .03 |
| j Total. Other Benefits | | | 23,738,710. | 19,310,902. | 4,427,808. | 1.94 |
| k Total. Add lines 7d and 7j | | | 92,935,384. | 75,096,035. | 17,839,349. | 7.83 |

**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 | | | 202. | | 202. | |
| 2 Economic development | | | | | | |
| 3 Community support | | | | | | |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | 169,504. | | 169,504. | |
| 9 Other | | | | | | |
| 10 Total | | | 169,706. | | 169,706. | |

**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 3,295,553. | | | |
| 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 2,306,887. | | | |
| 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 94,305,076. |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 6 86,782,623. |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 7,522,453. |

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**

| | | Yes | No |
|---|---|---|---|
| 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 % |
|---|---|---|---|---|
| 1 H. L. CANCER CTR | OUTPATIENT CANCER TREATMENT | 50.00000 | | |
| 2 HEART CTR OF FW | CARDIAC SERVICES MSO | 50.00000 | | |
| 3 SM INDEMNITY GROUP | INSURANCE COMPANY | 100.00000 | | |
| 4 FRANKLIN MEDICAL | PRIMARY CARE PHYSICIAN PRACT | | | 100.00000 |
| 5 DIAGNOSTIC IMAGING | OUTPATIENT IMAGING CENTER | 60.00000 | | |
| 6 NAUGATUCK VALLEY MRI | MAGNETIC IMAGING | 48.00000 | | |
| 7 SM PHYSICIAN PTRS. | ACCOUNTABLE CARE ORG. | 100.00000 | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

**Part V Facility Information**

**Section A. Hospital Facilities**

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? 1

| Name, address, primary website address, and state license number | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (describe) | Facility reporting group |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 SAINT MARY'S HOSPITAL INCORPORATED<br>56 FRANKLIN STREET<br>WATERBURY CT 06706 | X | X | | X | | | X | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

**Part V Facility Information** *(continued)*

**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

**Name of hospital facility or facility reporting group** SAINT MARY'S HOSPITAL INCORPORATED

**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 1 2 | | | |
| 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 | [X] 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 | [X] Inclusion of a community benefit section in operational plans | | | |
| f | [X] 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)*

**Financial Assistance Policy** SAINT MARY'S HOSPITAL INCORPORATED

| | | | Yes | No |
|---|---|---|---|---|
| | 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: 2 5 0 % | | | |
| | 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: 4 0 0 % | | | |
| | 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 | [X] Medical indigency | | | |
| d | [X] Insurance status | | | |
| e | [X] Uninsured discount | | | |
| f | [X] Medicaid/Medicare | | | |
| g | [X] 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 | [ ] Reporting to credit agency | | | |
| b | [ ] Lawsuits | | | |
| c | [ ] 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)* SAINT MARY'S HOSPITAL INCORPORATED

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)

**Changes 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? | 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? | 22 | | X |

If "Yes," explain in Section C.

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 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.

PART V, LINE 20D

FREE CARE IS PROVIDED FOR UNINSURED INDIVIDUALS WHOSE INCOME IS BELOW 250% OF THE FEDERAL POVERTY INCOME LEVELS. FOR UNINSURED PATIENTS WHOSE INCOME ARE BETWEEN 251% AND 350% OF THE FEDERAL POVERTY INCOME LEVELS, SMH WILL REDUCE THEIR BILL BY SLIDING SCALE DISCOUNT OR TO "COST OF PROVIDING SERVICES", AS ESTABLISHED BY THE OFFICE OF HEALTH CARE ACCESS (OHCA), WHICHEVER IS GREATER.

UNINSURED PATIENTS, WHOSE INCOME RANGE BETWEEN 351% AND 400% OF THE FEDERAL POVERTY INCOME LEVELS, WILL BE ELIGIBLE FOR AN ADDITIONAL CHARITY CARE REDUCTION OF 20% OFF OF THEIR REMAINING ACCOUNT(S) BALANCE(S).

PART V, LINE 3

SAINT MARY'S RECEIVED SIGNIFICANT INPUT FROM PERSONS REPRESENTING THE COMMUNITY. THE ASSESSMENT WAS CONDUCTED IN COLLABORATION WITH THE NEWLY FORMED GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (GWHIP), WHICH INCLUDES SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL, THE WATERBURY DEPARTMENT OF HEALTH, UNITED WAY OF GREATER WATERBURY, STAYWELL HEALTH CENTER, AND THE CONNECTICUT COMMUNITY FOUNDATION. IN ADDITION, GWHIP HOSTED A PRIORITIZATION SESSION THAT INCLUDED 41 INDIVIDUALS REPRESENTING LOCAL HEALTH AND HUMAN SERVICE AGENCIES, AREA NON-PROFIT ORGANIZATIONS, HEALTH PROVIDERS AND PUBLIC HEALTH REPRESENTATIVES. AT THIS PRIORITIZATION SESSION WHICH TOOK PLACE ON JUNE 18, 2013, THE GROUP VOTED ON COMMUNITY HEALTH PRIORITIES.

**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 SESSION INCLUDED 41 PARTICIPANTS FROM 29 ORGANIZATIONS INCLUDING BUT NOT LIMITED TO WATERBURY BOARD OF PUBLIC HEALTH, CATHOLIC CHARITIES ARCHDIOCES OF HARTFORD, UCONN SCHOOL OF PUBIC HEALTH, END HUNGER CONNECTICUT, VNA HEALTH-AT-HOME, BRIDGE TO SUCCESS, HEART CENTER OF GREATER WATERBURY AND THE CHAMBER OF COMMERCE. A LISTING OF PARTICIPANTS IS AVAILABLE UPON REQUEST.

PART V, LINE 4

WATERBURY HOSPITAL

PART V, LINE 5C

GWHIP HOSTED A "HEALTH SUMMIT" AT NAUGATUCK VALLEY COMMUNITY COLLEGE ON OCTOBER 4, 2013. MEMBERS OF THE PUBLIC WERE INVITED TO ATTEND. OVER 100 PEOPLE ATTENDED THE EVENT.

AT THE HEALTH SUMMIT, GWHIP REPRESENTATIVES PRESENTED THE CHNA FINDINGS. GWHIP ALSO CONVENED WORK GROUPS TO ADDRESS IDENTIFIED AREAS OF COMMUNITY HEALTH NEED.

PART V, LINE 7

SAINT MARY'S HOSPITAL ADMINISTRATORS DECIDED TO FOCUS ON THE TOP FOUR COMMUNITY HEALTH NEEDS (ACCESS TO CARE; MENTAL HEALTH/SUBSTANCE ABUSE; CHRONIC DISEASES (OBESITY, HEART DISEASE, DIABETES, AND ASTHMA); AND TOBACCO USE). THESE NEEDS WERE SELECTED AT THE "PRIORITIZATION SESSION" THAT WAS HELD ON JUNE 18, 2013.

**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.

DUE TO LIMITED TIME AND RESOURCES, SAINT MARY'S IS UNABLE TO ADDRESS EACH IDENTIFIED COMMUNITY HEALTH NEED. COMMUNITY ORGANIZATIONS ARE ADDRESSING THE OTHER IDENTIFIED HEALTH NEEDS. FOR EXAMPLE, THE WATERBURY HEALTH DEPARTMENT AND NEW OPPORTUNITIES, INC. ARE BOTH ADDRESSING "LOW BIRTH WEIGHT" BABIES THROUGH THE WOMEN, INFANTS, AND CHILDREN (WIC) NUTRITION PROGRAM. THE WATERBURY HEALTH DEPARTMENT AND NEW OPPORTUNITIES, INC. ADMINISTER THE WIC PROGRAM LOCALLY.

**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? 9

| Name and address | Type of Facility (describe) |
|---|---|
| 1 NAUGATUCK VALLEY SURGICAL CENTER<br>160 ROBBINS STREET, SUITE 1<br>WATERBURY CT 06708 | SURGICAL CENTER |
| 2 THE HAROLD LEEVER CANCER CENTER<br>1075 CHASE PARKWAY<br>WATERBURY CT 06708 | CANCER CENTER |
| 3 SAINT MARY'S MEDICAL IMAGING CENTER<br>475 CHASE PARKWAY<br>WATERBURY CT 06708 | MRI SERVICES |
| 4 SLEEP DISORDER CENTER<br>1312 WEST MAIN STREET<br>WATERBURY CT 06708 | SLEEP CARE |
| 5 OCCPUATION HEALTH & DIAG. CENTER<br>146 HIGHLAND AVENUE<br>WATERBURY CT 06708 | OCCUPATIONAL HEALTH, OCCUPATIONAL THERAPY, PHYSICAL THERAPY |
| 6 HEART CENTER OF GREATER WATERBURY<br>1075 CHASE PARKWAY<br>WATERBURY CT 06708 | CARDIAC CARE |
| 7 ST. MARY'S HOSP. URGENT CARE - NAUGATUCK<br>799 NEW HAVEN ROAD<br>NAUGATUCK CT 06770 | LAB, RADIOLOGY, URGENT CARE |
| 8 ST. MARY'S HOSP. URGENT CARE - WOLCOTT<br>503 WOLCOTT ROAD<br>WOLCOTT CT 06716 | LAB, RADIOLOGY, URGENT CARE |
| 9 ST. MARY'S MEDICAL ONCOLOGY CENTER<br>1075 CHASE PARKWAY<br>WATERBURY CT 06708 | ONCOLOGY |
| 10 | |

**Part VI Supplemental Information**

Provide the following information.

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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.

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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 6A

SAINT MARY'S HOSPITAL COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING THE FISCAL YEAR ENDED 9/30/2013. THE CHNA IS ACCESSIBLE BY CLICKING "ABOUT US" AND "HEALTH NEEDS ASSESSMENT BUTTON" ON THE SAINT MARY'S WEBSITE AT WWW.STMH.ORG.

PART I, LINE 7A

MANY PATIENTS WITHOUT INSURANCE DO NOT COMPLETE THE APPLICATION FOR CHARITY CARE. THE HOSPITAL, UPON PERFORMING AN ASSET VERIFICATION, MAKES A DETERMINATION WHETHER THE PATIENT WOULD HAVE QUALIFIED FOR THE CHARITY CARE. DURING 2012, THE COSTS ASSOCIATED WITH THE CHARGES FOREGONE RELATED TO THESE PATIENTS WERE APPROXIMATELY $1,340,000. DURING 2013 AND 2014, A SYSTEM CONVERSION LIMITED THE HOSPITAL'S ABILITY TO UNDERTAKE AN ASSET VERIFICATION. AS SUCH, THESE COSTS ARE CLASSIFIED IN THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS. THE HOSPITAL BELIEVES THAT HAD IT PERFORMED THE ASSET VERIFICATIONS IN 2014, COSTS ASSOCIATED WITH THESE PATIENTS WOULD HAVE BEEN FAIRLY CONSISTENT WITH 2012.

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PART I, LINE 7, COLUMN F

THE PERCENT OF TOTAL EXPENSE IN PART 1, LINE 7, COLUMN (F) IS CALCULATED BY DIVIDING COLUMN (E), NET COMMUNITY BENEFIT EXPENSE, BY TOTAL EXPENSE. THE BAD DEBT EXPENSE OF $10,078,145 WAS SUBTRACTED FROM THE TOTAL EXPENSE VALUE USED TO CALCULATE THE PERCENTAGES IN PART 1, LINE 7, COLUMN (F).

PART I, LINE 7

FOR PART 1, LINE 7 SECTIONS (A) CHARITY CARE AT COST, (B) UNREIMBURSED MEDICAID, (C) UNREIMBURSED COSTS-OTHER MEANS-TESTED GOVERNMENT PROGRAMS THE COSTING METHODOLOGY USED WAS THE COST-TO-CHARGE RATIO USING THE INCOME STATEMENT METHOD. THE COST-TO-CHARGE RATIO WAS DERIVED FROM THE YEAR-END GENERAL LEDGER, CALCULATED BY DIVIDING GROSS EXPENSE (LESS BAD DEBT) MINUS OTHER OPERATING REVENUE BY GROSS PATIENT CHARGES AND APPLIED BY CHARGE LINE APPROPRIATELY. SECTIONS (E) COMMUNITY HEALTH IMPROVEMENT; PORTIONS OF (F) HEALTH PROFESSIONS EDUCATION, (G) SUBSIDIZED HEALTH SERVICES, (H) RESEARCH, AND (I) CASH AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS ARE COMPRISED (EXCEPT FOR CASH DONATIONS AND IN-KIND MATERIAL DONATIONS) OF 1) SUPPLY EXPENSES; 2) PURCHASED SERVICES; 3)

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TUITION WAIVERS; AND 4) THE DIRECT SALARY COSTS FOR STAFF COMPENSATED BY THE HOSPITAL AND SPENT TIME PARTICIPATING IN ACTIVITIES THAT QUALIFY AS COMMUNITY BENEFITS.

THE INTERN, RESIDENT AND FELLOW PORTION OF SECTION (F) HEALTH PROFESSIONS EDUCATION ALSO INCLUDES THE SALARIES, FRINGE BENEFITS AND OTHER EXPENSES OF THE RESIDENCY PROGRAM DERIVED FROM THE GENERAL LEDGER. INDIRECT COSTS WERE ALSO APPLIED. THE COST ACCOUNTING METHODOLOGY WAS USED TO DETERMINE NET COMMUNITY BENEFIT EXPENSE FOR (G) SUBSIDIZED HEALTH SERVICES, WHICH INCLUDE IP AND OP PSYCHIATRY SERVICE LINES AND SERIES/RECURRING.

PART III, LINE 4

THE FINANCIAL STATEMENTS DO NOT HAVE A FOOTNOTE FOR BAD DEBT EXPENSE BUT BELOW IS THE FOOTNOTE FOR THE ALLOWANCE FOR BAD DEBTS.

THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER THEIR FINANCIAL ASSISTANCE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN THEIR ESTABLISHED RATES. BECAUSE THE HOSPITAL DOES NOT ANTICIPATE

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COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE. THE HOSPITAL GRANTS CREDIT WITHOUT COLLATERAL TO PATIENTS, MOST OF WHOM ARE LOCAL RESIDENTS AND ARE INSURED UNDER THIRD-PARTY ARRANGEMENTS. ADDITIONS TO THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS ARE MADE BY MEANS OF THE FOR BAD DEBTS. ACCOUNTS WRITTEN OFF AS UNCOLLECTIBLE ARE DEDUCTED FROM THE ALLOWANCE AND SUBSEQUENT RECOVERIES ARE ADDED. THE AMOUNT OF THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL AND STATE GOVERNMENTAL HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS.

PART III, SECTION A: LINES 2 & 3

THE HOSPITAL USED A COST TO CHARGE RATIO TO CALCULATE THE AMOUNTS RECORDED IN LINES 2 AND 3. WE REASONABLY ESTIMATED THE AMOUNT OF BAD DEBTS THAT WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S CHARITY CARE POLICY, IF THE PATIENTS WOULD HAVE APPLIED OR PROVIDED SUFFICIENT INFORMATION. WE DID NOT INCLUDE THIS AMOUNT IN THE COMMUNITY BENEFIT.

**Part VI Supplemental Information**

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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 III, LINE 8

THERE IS NO SHORTFALL REPORTED IN LINE 7, THEREFORE, WE DID NOT INCLUDE IN COMMUNITY BENEFIT. WE UTILIZED THE COST TO CHARGE RATIO TO ESTIMATE THE MEDICARE ALLOWABLE COSTS OF CARE.

PART III, LINE 9B

A PATIENT MAY REQUEST CHARITY CARE AT ANY TIME IN THE BILLING AND COLLECTION PROCESS. IF THE HOSPITAL, ITS COLLECTION AGENT, OR ITS ATTORNEY BECOMES AWARE THAT THE PATIENT OR GUARANTOR REQUESTS CHARITY CARE, THE COLLECTION PROCESS WILL BE PROMPTLY DISCONTINUED WHILE THE ELIGIBILITY STATUS OF THE PATIENT OR GUARANTOR REQUESTING ASSISTANCE IS DETERMINED. WHENEVER IT IS DETERMINED THAT THE PATIENT QUALIFIES FOR CHARITY CARE, THE FINANCIAL COUNSELOR WILL ADJUST THE BALANCE BY THE APPROPRIATE AMOUNT, AND ANY RESULTING BALANCE WILL BECOME THE PATIENT'S RESPONSIBILITY.

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PART VI, LINE 2

SAINT MARY'S HAS AN ANNUAL STRATEGIC PLANNING PROCESS THAT IDENTIFIES UNMET COMMUNITY NEEDS WHILE DEPLOYING STRATEGIES TO ADDRESS THESE UNMET COMMUNITY NEEDS AND IMPROVE OUR OVERALL COMMUNITY BENEFIT. SAINT MARY'S ALSO WORKS CLOSELY WITH MANY LOCAL CHARITABLE COMMUNITY SERVICE ORGANIZATIONS TO BOTH IDENTIFY AND ADDRESS COMMUNITY NEEDS.

SAINT MARY'S HOSPITAL (SMH) INDIVIDUAL COMMUNITY BENEFIT PROGRAMS HAVE BEEN DESIGNED TO MEET THE LONG-STANDING NEEDS OF INDIVIDUALS LIVING IN THE SERVICE AREA. TO IDENTIFY NEED, SMH HAS RELIED ON EXISTING LOCAL AND REGIONAL NEEDS ASSESSMENTS INCLUDING: UNITED WAY OF GREATER WATERBURY'S COMMUNITY STATUS REPORT (2013); UNITED WAY'S TEN-YEAR PLAN TO END HOMELESSNESS (2013); THE CENTERS FOR DISEASE CONTROL AND PREVENTION BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (2013); CONNECTICUT DEPARTMENT OF PUBLIC HEALTH STATE HEALTH ASSESSMENT (2013); AND THE CONNECTICUT HEALTH CARE SURVEY (2013) BY THE CONNECTICUT HEALTH FOUNDATION.

IN ADDITION, THE HOSPITAL USES CONNECTICUT HOSPITAL ASSOCIATION (CHA)

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ONLINE TOOLS WHICH INCLUDE THE CHIME DECISION SUPPORT TOOL AND CHIME MAPS TO UNDERSTAND SERVICE AREA NEEDS. THE HOSPITAL USES THE CENSUS BUREAU DATABASES AS WELL AS DEMOGRAPHIC REPORTS AVAILABLE THROUGH CLARITAS DATABASES.

BETWEEN 2012 AND 2013, SAINT MARY'S CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). SAINT MARY'S REACHED OUT TO LOCAL ORGANIZATIONS AND FORMED THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (THE PARTNERSHIP). THE PARTNERSHIP INCLUDES LOCAL NON-PROFIT ORGANIZATIONS (SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL, THE WATERBURY DEPARTMENT OF HEALTH, UNITED WAY OF GREATER WATERBURY, STAYWELL HEALTH CENTER, AND THE CONNECTICUT COMMUNITY FOUNDATION). PARTNERSHIP MEMBERS EACH CONTRIBUTED FINANCIAL RESOURCES TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT.

DATA COLLECTION AND RESEARCH

SAINT MARY'S CONTRACTED WITH HOLLERAN, AN INDEPENDENT RESEARCH AND CONSULTING FIRM LOCATED IN LANCASTER, PENNSYLVANIA, TO CONDUCT RESEARCH IN SUPPORT OF THE CHNA. THE CHNA INCLUDED BOTH QUALITATIVE AND

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QUANTITATIVE DATA COLLECTION METHODS. QUALITATIVE DATA WERE COLLECTED THROUGH BOTH A KEY INFORMANT ONLINE SURVEY AND SIX FOCUS GROUPS. TWO HUNDRED FIVE COMMUNITY LEADERS, PARTNERS AND HEALTH CARE PROVIDERS PARTICIPATED IN THE ONLINE KEY INFORMANT SURVEY. TWO FOCUS GROUPS WITH HEALTHCARE PROVIDERS WERE HELD AT EACH OF THE HOSPITALS; 24 HEALTH CARE PROVIDERS PARTICIPATED. FOUR FOCUS GROUPS WERE HELD AT NEIGHBORHOOD ASSOCIATIONS IN WATERBURY; 33 LOCAL RESIDENTS PARTICIPATED.

QUANTITATIVE DATA WERE COLLECTED THROUGH A STATISTICAL HOUSEHOLD TELEPHONE SURVEY OF 1,100 PEOPLE IN THE SAINT MARY'S SERVICE AREA. THE STATISTICAL HOUSEHOLD SURVEY WAS BASED ON THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS) STUDY DEVELOPED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC). THE SURVEY ASSESSED INDICATORS SUCH AS GENERAL HEALTH STATUS, PREVENTION ACTIVITIES (SCREENINGS, ETC.) AND RISK 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 SAINT

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MARY'S SERVICE AREA. IN ADDITION TO THE HOUSEHOLD SURVEY, SECONDARY DATA WERE ALSO ANALYZED AS PART OF THE CHNA.

PRIORITIZATION

ON JUNE 18, 2013, THE PARTNERSHIP HELD A PRIORITIZATION SESSION THAT INCLUDED 40 INDIVIDUALS REPRESENTING LOCAL HEALTH AND HUMAN SERVICE AGENCIES, AREA NON-PROFIT ORGANIZATIONS, HEALTH PROVIDERS AND PUBLIC HEALTH REPRESENTATIVES. THE OBJECTIVES OF THE PRIORITIZATION SESSION WERE TO REVIEW THE RECENTLY COMPILED COMMUNITY HEALTH DATA AND HIGHLIGHT KEY RESEARCH FINDINGS; TO GATHER FEEDBACK FROM THE COMMUNITY REPRESENTATIVES; AND TO PRIORITIZE THE COMMUNITY HEALTH NEEDS BASED ON SELECTED CRITERIA.

ATTENDEES VOTED ON THE TOP FOUR PRIORITY AREAS. THE SELECTED PRIORITIES ARE (1) ACCESS TO CARE; (2) MENTAL HEALTH AND SUBSTANCE ABUSE; (3) CHRONIC DISEASES - OBESITY, DIABETES, HEART DISEASE AND ASTHMA; AND (4) SMOKING.

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IMPLEMENTATION STRATEGY

SAINT MARY'S HOSPITAL DEVELOPED AN IMPLEMENTATION STRATEGY TO ILLUSTRATE SPECIFIC PROGRAMS AND RESOURCES THAT SUPPORT THESE IDENTIFIED COMMUNITY HEALTH PRIORITIES. THE IMPLEMENTATION STRATEGY WAS ADOPTED BY THE SAINT MARY'S BOARD OF DIRECTORS ON SEPTEMBER 12, 2013. THE IMPLEMENTATION STRATEGY IS ATTACHED TO THIS FILING. THE CHNA SUMMARY REPORT AND IMPLEMENTATION STRATEGY ARE ALSO AVAILABLE ON THE HOSPITAL'S WEBSITE (WWW.STMH.ORG).

ONCE THE IMPLEMENTATION STRATEGY WAS CREATED, CONTINUED MONTHLY MEETINGS WITH THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP WERE DONE TO ENSURE TAHT EACH ORGANIZATION STAYED ON TRACK WITH THE NEEDS OF THE COMMUNITY. THERE ARE SEVERAL REPRESENATIVES FROM SAINT MARY'S THAT ATTEND THESE MEETINGS EACH MONTH TO NOT ONLY IMPROVE THE HOSPITAL WITH INCREMENTAL CHANGES, BUT THE GREATER WATERBURY COMMUNITY AS A WHOLE. CONTINUED COLLABORATION AND MANAGEMENT OF THE IMPLEMENTATION STRATEGIES ARE DISCUSSED WITH THE COMMUNITY PARTNERS EACH MONTH.

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PART VI, LINE 3

THERE ARE BROCHURES AND SIGNAGE IN FOUR LANGUAGES INDICATING THAT FINANCIAL ASSISTANCE IS AVAILABLE TO QUALIFIED PATIENTS AND THEIR FAMILIES. SIGNAGE IS LOCATED IN REGISTRATION, EMERGENCY DEPARTMENT, ALL SOCIAL SERVICES DEPARTMENTS, CASHIER'S OFFICE, PATIENT FINANCIAL SERVICES AND THE LOBBY. THE SIGNAGE EXPLAINS THE POLICY AND HOW TO APPLY. IN ADDITION, FINANCIAL COUNSELORS ARE AVAILABLE TO MEET WITH INDIVIDUAL PATIENTS TO ASSIST DURING THE PROCESS.

ALL FAMILIES OF ELIGIBLE CHILDREN, REGARDLESS OF INCOME, RECEIVE CARE COORDINATION SERVICES IN PARTNERSHIP WITH THEIR CHILD'S MEDICAL HOME UNDER THE SAINT MARY'S PROGRAM. FAMILY AND COMMUNITY REFERRALS, DIRECT SERVICES, ADVOCACY AND LINKS TO PARENT SUPPORT SERVICES ARE ALSO PROVIDED. A LIMITED NUMBER OF FAMILIES RECEIVE RESPITE AND CAMP FUNDS. UNINSURED OR UNDERINSURED FAMILIES WHO FALL WITHIN THE TITLE V EXTENDED SERVICE FUNDS ELIGIBILITY GUIDELINES CAN ALSO BENEFIT FROM PAYMENT FOR EXTENDED SERVICES (I.E. DURABLE MEDICAL EQUIPMENT, PRESCRIPTIONS,

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SPECIALTY VISITS, THERAPIES AND SPECIAL NUTRITIONAL FORMULAS).

PATIENT FINANCIAL AID SAINT MARY'S HOSPITAL PROVIDES FINANCIAL ASSISTANCE TO PATIENTS WHO QUALIFY FOR THE HOSPITAL'S "BED FUND" OR OTHER FINANCIAL ASSISTANCE PROGRAMS.

IF A PATIENT IS UNINSURED OR OTHERWISE UNABLE TO PAY HIS OR HER MEDICAL BILLS, HE OR SHE MAY QUALIFY FOR THE HOSPITAL BED FUND. IN ORDER TO QUALIFY, A PATIENT MUST MEET CERTAIN CRITERIA, INCLUDING HAVING A HOUSEHOLD INCOME AT OR BELOW 400% OF THE FEDERAL POVERTY LIMITS.

IF A PATIENT QUALIFIES FOR THE "BED FUND," OR ANY OTHER FINANCIAL ASSISTANCE PROGRAMS, THE PATIENT WILL BE NOTIFIED WITHIN THIRTY (30) DAYS OF RECEIPT OF APPLICATION. IF A PATIENT'S APPLICATION IS DENIED, AN EXPLANATION WILL BE PROVIDED. THE PATIENT MAY REAPPLY AT ANY TIME AND THE APPLICATION WILL BE REASSESSED BASED ON THE AVAILABILITY OF ADDITIONAL FUNDS OR A CHANGE IN THE PATIENT'S FINANCIAL STATUS.

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PART VI, LINE 4

SAINT MARY'S TOTAL SERVICE AREA IS COMPRISED OF 35 ZIP CODES, WHICH INCLUDE THE CITY OF WATERBURY AND 17 SURROUNDING TOWNS. THE PRIMARY SERVICE AREA (WHICH INCLUDES WATERBURY, NAUGATUCK, PROSPECT AND WOLCOTT, CT) HAS A POPULATION OF APPROXIMATELY 165,400. THE SECONDARY SERVICE AREA HAS A POPULATION OF APPROXIMATELY 144,600. THE MAJORITY OF SAINT MARY'S HOSPITAL PATIENTS LIVE IN THE CITY OF WATERBURY WHICH IS PARTICULARLY ECONOMICALLY DISTRESSED. THE MEDIAN HOUSEHOLD INCOME IS $40,867, WHICH IS SIGNIFICANTLY LESS THAN THE OVERALL SERVICE AREA, WHICH IS APPROXIMATELY $69,500. THE UNEMPLOYMENT RATE IN THE CITY OF WATERBURY IN SEPTEMBER 2014 WAS 12.5%. THIS IS HIGHER THAN THE STATE OF CONNECTICUT UNEMPLOYMENT RATE OF 7.8% APPROXIMATELY 35.9% OF THE POPULATION IN WATERBURY SPEAKS A LANGUAGE OTHER THAN ENGLISH IN THE HOME. THIS IS HIGHER THAN THE STATE OF CONNECTICUT WHERE 23.8% OF THE POPULATION SPEAKS A LANGUAGE OTHER THAN ENGLISH IN THE HOME. IN ADDITION, 17.1% OF FAMILIES IN WATERBURY HAVE POVERTY STATUS COMPARED TO 6.7% IN CONNECTICUT.

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CENTRAL WATERBURY HAS BEEN DESIGNATED A MEDICALLY UNDERSERVED AREA (MUA) AND MEDICALLY UNDERSERVED POPULATION (MUP) BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA). HRSA HAS ALSO DESIGNATED CENTRAL WATERBURY AS A HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) FOR PRIMARY MEDICAL CARE, DENTAL CARE AND MENTAL HEALTH.

PART II AND PART VI, LINE 5

SMH'S COMMUNITY BUILDING ACTIVITIES INCLUDE THE FOLLOWING: DISASTER PREPAREDNESS; CONTRIBUTIONS TO THE WATERBURY ELIMINATES LEAD HAZARDS PROGRAM; HEALTH CARE ADVOCACY; A VARIETY OF WORKFORCE DEVELOPMENT INITIATIVES INCLUDING LECTURES TO ADDRESS HEALTHCARE WORKFORCE SHORTAGES, RECRUITING MINORITIES AND DIVERSE LANGUAGES, AND SPEAKING TO YOUTH ABOUT CAREERS IN HEALTHCARE; PARTICIPATION IN THE CONNECTICUT HOSPITAL ASSOCIATION'S DIVERSITY COLLABORATIVE; UNITED WAY DAY OF CARING; AND PUBLIC LANDSCAPE ENHANCEMENT AMONG OTHERS. THESE ACTIVITIES PROMOTE HEALTH IN MANY WAYS. THE EFFORTS OF OUR DISASTER PREPAREDNESS COMMITTEE ABOVE AND BEYOND WHAT IS REQUIRED OF THEM HELPS TO PREPARE OUR STAFF AND COORDINATE PLANS WITH OTHER LOCAL AGENCIES (FIRE, POLICE, ETC) IN THE

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EVENT THAT A LOCAL DISASTER WOULD OCCUR. THE WATERBURY ELIMINATES LEAD HAZARDS PROGRAM COLLABORATES WITH OTHER LOCAL AGENCIES TO IDENTIFY LEAD HAZARDS IN THE COMMUNITY AND EDUCATE AND TREAT INDIVIDUALS IN AN EFFORT TO PREVENT LEAD HAZARDS THROUGHOUT THE COMMUNITY. A VARIETY OF SMH STAFF ADVOCATE FOR HEALTHCARE REFORM BOTH LOCALLY AND AT THE STATE LEVEL IN AN EFFORT TO IMPROVE ACCESS TO HEALTHCARE AND PUBLIC HEALTH. THE VARIOUS WORKFORCE DEVELOPMENT INITIATIVES ASSURE ACCESS TO HEALTHCARE SERVICES IN OUR COMMUNITY WHILE MAINTAINING HUMAN RESOURCES. BOTH THE UNITED WAY DAY OF CARING AND PUBLIC LANDSCAPE ENHANCEMENT CLEAN UP OUR COMMUNITIES TO PROVIDE A SAFE AND HEALTHY ENVIRONMENT FOR EVERYONE TO WORK, PLAY AND LIVE.

PART II AND PART VI, LINE 5

SAINT MARY'S HOSPITAL OFFERS A VARIETY OF FREE PROGRAMS AND SERVICES THAT ARE SUBSIDIZED BY THE HOSPITAL. FROM MEDICAL AND SURGICAL SERVICES FOR THE UNINSURED AND UNDERINSURED TO HEALTH EDUCATION, SUPPORT GROUPS AND COMMUNITY OUTREACH PROGRAMS, SAINT MARY'S PLAYS AN INTEGRAL ROLE IN THE COMMUNITY WHILE RESPONDING TO THE UNIQUE HEALTHCARE NEEDS OF THE

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RESIDENTS OF GREATER WATERBURY.

EXAMPLES OF SAINT MARY'S MANY COMMUNITY BENEFIT PROGRAMS AND SERVICES PROGRAM, WHICH PROVIDES FREE MAMMOGRAMS FOR WOMEN WHO ARE AGE 40 OR OLDER AND HAVE LITTLE OR NO HEALTH INSURANCE. SAINT MARY'S IS THE ONLY HOSPITAL IN WATERBURY OFFERING THIS PROGRAM, WHICH HAS ASSISTED MORE THAN 2,500 WOMEN SINCE 1995. THE PROGRAM IS OFFERED THROUGH SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER. OTHER EXAMPLES OF SAINT MARY'S COMMUNITY BENEFIT PROGRAMS AND SERVICES INCLUDE SUPPORT GROUPS THAT ARE HOSTED AND SUPPORTED BY THE HOSPITAL FOR PATIENTS SUFFERING FROM ASTHMA AND OUR "BEYOND GRIEF" GROUP PROVIDES BEREAVEMENT SUPPORT FOR ADULTS.

ONE OF THE PROGRAMS THAT HAS HAD AN IMPACT IS CALLED "TEEN GRIEF," WHICH PROVIDES CONFIDENTIAL BEREAVEMENT SUPPORT TO STUDENTS OF LOCAL MIDDLE AND HIGH SCHOOLS. ESTABLISHED BY A PEDIATRIC SOCIAL WORKER FROM SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER IN THE WAKE OF THE TERRORIST ATTACKS OF SEPTEMBER 2001, THIS PROGRAM IS SUPPORTED IN PART BY A GRANT FROM THE J. WALTON BISSELL FOUNDATION. THIS IN SCHOOL PROGRAM ALLOWS TEENS TO COPE

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WITH THEIR GRIEF IN A POSITIVE WAY AND PROVIDES THEM WITH A SAFE PLACE TO EXPRESS THEIR FEELINGS AND LEARN FROM THE EXPERIENCES OF THEIR PEERS. IN ADDITION TO THESE PROGRAMS SAINT MARY'S ALSO HAS SUCCESSFUL PARTNERSHIPS WITH OTHER COMMUNITY ORGANIZATIONS SUCH AS THE GREATER WATERBURY UNITED WAY, WELLPATH BEHAVIORAL HEALTH FOR CHILDREN AND FAMILIES, AND THE MORRIS FOUNDATION, WHICH OFFERS TREATMENT, PREVENTION, EDUCATION, AND RECOVERY SUPPORT FOR INDIVIDUALS WITH SUBSTANCE ABUSE AND BEHAVIORAL HEALTH ISSUES. THE HOSPITAL HAS ALSO FORGED COLLABORATIONS TO BRING WORLD-CLASS HEALTHCARE SERVICES TO THE COMMUNITY THROUGH: - THE HAROLD LEEVER REGIONAL CANCER CENTER, A FREESTANDING 40,000-SQUARE-FOOT FACILITY DEDICATED TO OUTPATIENT CANCER CARE, WHICH IS A JOINT VENTURE PARTNERSHIP BETWEEN SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL; - THE HEART CENTER OF GREATER WATERBURY, WHICH PROVIDES ADVANCED CARDIAC SERVICES, INCLUDING ANGIOPLASTY AND OPEN HEART SURGERY, THROUGH A PARTNERSHIP BETWEEN SAINT MARY'S HOSPITAL, WATERBURY HOSPITAL AND THE UNIVERSITY OF CONNECTICUT HEALTH CENTER/JOHN DEMPSEY HOSPITAL. EXTENDING ITS REACH.

SAINT MARY'S CHILDREN'S AND FAMILY HEALTH CENTER HAS BEEN RECOGNIZED BY

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THE CONNECTICUT LEGISLATURE, STATE CHILD ADVOCACY GROUPS AND THE NATIONAL INITIATIVE FOR CHILD HEALTHCARE QUALITY AS A LEADER AND MODEL PRACTICE IN THE CARE OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS BASED ON ITS "MEDICAL HOME" MODEL OF CARE.

FORMALLY KNOWN AS THE NORTHWEST REGIONAL MEDICAL HOME SUPPORT CENTER, THIS HOSPITAL-BASED PROGRAM PROVIDES ASSISTANCE TO CAREGIVERS OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS AND HAS EXPANDED TO FIVE LOCATIONS: SAINT MARY'S CHILDREN'S HEALTH CENTER, LITCHFIELD COUNTY PEDIATRICS IN TORRINGTON, PEDIATRIC ASSOCIATES OF WESTERN, CT, PEDIATRIC ASSOCIATES OF CT AND THE MEDICAL/PEDIATRICS RESIDENCY TRAINING PROGRAM OPERATED JOINTLY BY SAINT MARY'S HOSPITAL AND YALE-NEW HAVEN HOSPITAL.

THE PROGRAM PROVIDES:

- CARE COORDINATION
- FAMILY SUPPORT
- ADVOCACY
- TITLE V FUNDS

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O BENEFITS COORDINATION

WORKING WITH CAREGIVERS, THE "MEDICAL HOME" PROGRAM HELPS CREATE CUSTOMIZED CARE PLANS AND BRINGS TOGETHER RESOURCES THAT FAMILIES WITH CHILDREN OF SPECIAL NEEDS DEPEND UPON. THE PROGRAM PARTNERS WITH PEDIATRIC CARE PROVIDERS TO MEET THE DIVERSE NEEDS OF CAREGIVERS AND FAMILIES OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS. WORKING THROUGH REHABILITATION AND SCHOOL SERVICES, COMMUNITY AGENCIES AND DEPARTMENT OF SOCIAL SERVICES, THE PROGRAM ESTABLISHES TRANSITION PLANS FOR CHILDREN LEAVING THE PROGRAM AT AGE 21. THE UNITED STATES MATERNAL AND CHILD HEALTH BUREAU DEFINES CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHCN) AS THOSE WHO HAVE OR ARE AT INCREASED RISK FOR: CHRONIC PHYSICAL, DEVELOPMENTAL, BEHAVIORAL OR EMOTION CONDITIONS (EXPECTED TO LAST AT LEAST A YEAR); AND THOSE WHO REQUIRE HEALTH AND RELATED SERVICES OF A TYPE OR AMOUNT BEYOND THAT REQUIRED BY CHILDREN GENERALLY. EIGHTEEN PERCENT OF CHILDREN IN THE UNITED STATES ARE INCLUDED IN THAT DEFINITION.

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IN ADDITION TO THE COMMUNITY BUILDING ACTIVITIES IDENTIFIED IN RESPONSE TO QUESTION 5 AND THE QUANTIFIED FREE OR DISCOUNTED HEALTH SERVICES IDENTIFIED IN THE REPORTED CHARITY CARE FIGURES, SMH PROVIDES OTHER COMMUNITY BENEFITS. EXAMPLES INCLUDE SCREENINGS, LECTURES, HEALTH FAIRS, SUPPORT GROUPS, CONSULTATIONS, REFERRALS TO OUTSIDE AGENCIES AND OTHERS.

HEALTH PROFESSIONS EDUCATION: SMH IS A TEACHING HOSPITAL AND IS COMMITTED TO PREPARING FUTURE HEALTHCARE PROFESSIONALS. THIS CATEGORY REPRESENTS THE MAJORITY OF SMH'S COMMUNITY BENEFIT ACTIVITIES AND INCLUDES EFFORTS TO GENERATE INTEREST IN HEALTH PROFESSIONS AS WELL AS PROVIDING A CLINICAL SITE FOR MEDICAL STUDENTS, HIGH SCHOOL STUDENTS AND COLLEGES FOR STUDENTS WHO ARE PURSUING DEGREES AS NURSES, PHYSICIAN ASSISTANTS (PA), OCCUPATIONAL, SPEECH AND PHYSICAL THERAPISTS, DENTAL HYGIENISTS, RADIOLOGY TECHNOLOGISTS AND MORE.

SUBSIDIZED SERVICES: SMH PROVIDES HEALTH SERVICES TO PATIENTS WITH NO INSURANCE OR STATE INSURANCE INCLUDING EMERGENCY SERVICES AND BEHAVIORAL

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HEALTH CLINICS.

FINANCIAL AND IN-KIND CONTRIBUTIONS: SMH FINANCIALLY SUPPORTS OTHER COMMUNITY ORGANIZATIONS THROUGH SPONSORSHIPS AND IN-KIND DONATIONS VIA TIME SPENT BY STAFF IN THE COMMUNITY ON LOCAL BOARDS AND VOLUNTEERING TIME FOR LOCAL ORGANIZATIONS.

COMMUNITY BENEFIT OPERATIONS: THE COSTS ASSOCIATED WITH PLANNING AND OPERATING COMMUNITY BENEFIT PROGRAMS ARE IN ITSELF A BENEFIT TO THE COMMUNITY. THIS CATEGORY ALSO INCLUDES COSTS ASSOCIATED WITH CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT AS WELL AS DEVELOPING AN IMPLEMENTATION STRATEGY.

RESEARCH

STATE CANCER REGISTRIES ENABLE PUBLIC HEALTH PROFESSIONALS TO BETTER UNDERSTAND AND ADDRESS CANCER. SUCH INFORMATION IS ESSENTIAL FOR IDENTIFYING WHEN AND WHERE CANCER SCREENING EFFORTS SHOULD BE ENHANCED AND FOR MONITORING THE TREATMENT PROVIDED TO CANCER PATIENTS. IN

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ADDITION, RELIABLE REGISTRY DATA IS FUNDAMENTAL TO A VARIETY OF RESEARCH EFFORTS, INCLUDING THOSE AIMED AT EVALUATING THE EFFECTIVENESS OF CANCER PREVENTION, CONTROL OR TREATMENT PROGRAMS. THE DATA IS REPORTED TO A CENTRAL STATEWIDE REGISTRY FROM VARIOUS MEDICAL FACILITIES INCLUDING HOSPITALS, PHYSICIANS' OFFICES, THERAPEUTIC RADIATION FACILITIES, FREESTANDING SURGICAL CENTERS AND PATHOLOGY LABORATORIES. DURING FISCAL YEAR 2014, THE TOTAL COST ASSOCIATED WITH THE SAINT MARY'S HOSPITAL CANCER REGISTRY WAS $165,239.

PART VI, LINE 6

SAINT MARY'S HOSPITAL PLAYS AN INDISPENSABLE ROLE IN THE HEALTHCARE DELIVERY SYSTEM FOR THE GREATER WATERBURY COMMUNITY AND THE TOWNS OF THE CENTRAL NAUGATUCK VALLEY. FOUNDED IN 1907 BY THE SISTERS OF SAINT JOSEPH OF CHAMBERY, SAINT MARY'S HAS BEEN THE CATHOLIC BEACON OF HEALING AND HOPE IN THE COMMUNITY FOR 100 YEARS. BUILT IN THE HEART OF THE CITY AND WITHIN CLOSE DISTANCE OF ITS ONCE-THRIVING BRASS MILLS SO THAT IT COULD RESPOND READILY TO INJURED WORKERS, THE HOSPITAL HAS EVOLVED INTO A DIVERSE HEALTH SYSTEM THAT TODAY PROVIDES A VARIETY OF HEALTHCARE,

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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.

EDUCATIONAL, FINANCIAL AND OTHER BENEFITS TO THE PEOPLE IT SERVES.

SMH AFFILIATED ORGANIZATIONS SHARE THE GOAL OF PROMOTING HEALTHY LIVING AND DISEASE DETECTION AND PREVENTION THROUGHOUT THE WATERBURY COMMUNITY.

THE HEART CENTER OF GREATER WATERBURY IS A PARTNERSHIP ORGANIZATION WITH SOLE MEMBERS: SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL. THE HEART CENTER PROMOTES HEALTHY LIVING AND CARDIOVASCULAR DISEASE DETECTION THROUGH SUPPORT GROUPS, SCREENINGS, COMMUNITY HEALTH BOARD INVOLVEMENT, AND COMMUNITY EDUCATION.

THE HAROLD LEEVER CANCER CENTER IS A PARTNERSHIP ORGANIZATION WITH SOLE MEMBERS: SAINT MARY'S HOSPITAL AND WATERBURY HOSPITAL. THE HAROLD LEEVER CANCER CENTER PROMOTES CANCER AWARENESS AND SUPPORT FOR PATIENTS THROUGH SUPPORT GROUPS, SCREENINGS AND COMMUNITY EDUCATION.

SAINT MARY'S HOSPITAL FOUNDATION IS A 501(C)(3) WHOLLY OWNED SUBSIDIARY

**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.

COMPANY OF SAINT MARY'S HEALTH SYSTEM. THE FOUNDATION SUPPORTS THE HOSPITAL'S MISSION BY RAISING MONEY TO BENEFIT A VARIETY OF COMMUNITY NEEDS.

FRANKLIN MEDICAL GROUP IS A CAPTIVE PROFESSIONAL CORPORATION OF MULTI-SPECIALTY PHYSICIANS AFFILIATED WITH SAINT MARY'S HOSPITAL. THE MEDICAL GROUP OPERATES THE CHILDREN'S AND FAMILY HEALTH CENTER, DENTAL CLINIC AND A VARIETY OF CLINICS OFTEN BENEFITING THE UNINSURED POPULATION. IN ADDITION TO PATIENT CARE, PATIENTS BENEFIT FROM A VARIETY OF FREE OR DISCOUNTED SERVICES.

PART VI, LINE 7

CT

PART I, LINE 3C

OUTSTANDING PATIENT ACCOUNT BALANCES LABELED AS SELF PAY, MAY BE SENT TO AN OUTSIDE VENDOR FOR VERIFICATION OF ASSETS. PATIENTS THAT ARE CLASSIFIED AS HAVING NO ASSETS WILL BE WRITTEN OFF TO CHARITY CARE.

**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" to 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: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

## 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 | | |
| 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 | CHAD WABLE<br>PRESIDENT AND CEO | (i) | 537,551. | 180,000. | 37,965. | 151,575. | 35,214. | 942,305. | 32,316. |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 | JAMES UBERTI, M.D.<br>DIRECTOR | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | (ii) | 204,314. | 0 | 774. | 6,176. | 3,851. | 215,115. | 0 |
| 3 | ROBERT RILEY, CFO<br>CFO (FORMER) | (i) | 225,836. | 0 | 581. | 9,211. | 23,636. | 259,264. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 | SANDRA ROOSA<br>VP PATIENT SVC | (i) | 0 | 0 | 221,872. | 17,750. | 19,007. | 258,629. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 | MICHAEL NOVAK<br>VP OPERATIONS | (i) | 231,837. | 57,061. | 414. | 11,700. | 27,846. | 328,858. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6 | CAROLYN ORRELL<br>CIO (FORMER) | (i) | 17,113. | 10,000. | 188,305. | 0 | 5,125. | 220,543. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 | M. CLARK KEARNEY<br>VP HUMAN RESOURCES | (i) | 199,507. | 48,644. | 1,218. | 10,951. | 25,711. | 286,031. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 8 | JOSEPH CONNOLLY<br>CHIEF MARKETING OFFICER | (i) | 160,067. | 24,959. | 331. | 9,403. | 27,667. | 222,427. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9 | STEPHEN SCHNEIDER, MD<br>CMO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | (ii) | 351,095. | 87,500. | 1,188. | 11,700. | 43,948. | 495,431. | 0 |
| 10 | GREG BULLER, MD<br>CHAIRMAN, DEPT. OF MEDICINE | (i) | 254,786. | 0 | 774. | 15,300. | 3,465. | 274,325. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 11 | ELIZABETH BOZZUTO<br>VP SURGICAL SERVICES | (i) | 231,261. | 57,288. | 1,553. | 26,134. | 21,656. | 337,892. | 0 |
| | | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 12 | | (i) | | | | | | | |
| | | (ii) | | | | | | | |
| 13 | | (i) | | | | | | | |
| | | (ii) | | | | | | | |
| 14 | | (i) | | | | | | | |
| | | (ii) | | | | | | | |
| 15 | | (i) | | | | | | | |
| | | (ii) | | | | | | | |
| 16 | | (i) | | | | | | | |
| | | (ii) | | | | | | | |

**Part III Supplemental Information**

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SCHEDULE J - PART I, LINE 4A

SANDRA ROOSA'S EMPLOYMENT CONTRACT INCLUDED A PROVISION FOR SALARY CONTINUATION. FOR PURPOSES OF SCHEDULE H, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION IN COLUMN B(III).

CAROLYN ORRELL RECEIVED A ONE YEAR SEVERANCE PACKAGE. THE AMOUNT IS INCLUDED IN COLUMN B(III).

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SCHEDULE J - PART I - LINE 4B

CHAD WABLE PARTICIPATES IN A 457(F) DEFERRED COMPENSATION PLAN. THE CONTRIBUTION FROM 2008 BECAME VESTED DURING FISCAL YEAR 2014. FOR PURPOSES OF SCHEDULE J, THE AMOUNT IS INCLUDED IN OTHER REPORTABLE COMPENSATION IN COLUMN B(III). IT IS ALSO LISTED IN COLUMN (F) AS IT WAS PREVIOUSLY REPORTED AS DEFERRED COMPENSATION ON A PRIOR FORM 990.

SCHEDULE J - PART I - QUESTION 6A

EACH SENIOR LEADER IS PROVIDED A BONUS BASED ON NET EARNINGS AND OTHER CORPORATE GOALS. THE BONUS IS CONTINGENT ON CORPORATE GOALS AND OBJECTIVES EACH YEAR. DURING FY2014, THERE WERE 5 OBJECTIVES: PEOPLE,

**Part III Supplemental Information**

Complete this part to 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.

SERVICE, QUALITY, FINANCE, AND GROWTH. THE BONUS IS COMPUTED ON A PERCENTAGE ALLOCATION FOR THE WEIGHT OF EACH OBJECTIVE WHICH IS DIFFERENT FOR EACH SENIOR LEADER BASED ON THEIR JOB FUNCTION.

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**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.*

OMB No. 1545-0047

**2013**

**Open To Public Inspection**

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

**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 |
|---|---|---|---|---|
| (1) | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |
| (5) | | | | |
| (6) | | | | |

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

**Part II** **Loans to and/or From Interested Persons.**
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

| (a) Name of interested person | (b) Relationship with organization | (c) Purpose of loan | (d) Loan to or from the organization? To | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (1) | | | | | | | | | | | | |
| (2) | | | | | | | | | | | | |
| (3) | | | | | | | | | | | | |
| (4) | | | | | | | | | | | | |
| (5) | | | | | | | | | | | | |
| (6) | | | | | | | | | | | | |
| (7) | | | | | | | | | | | | |
| (8) | | | | | | | | | | | | |
| (9) | | | | | | | | | | | | |
| (10) | | | | | | | | | | | | |
| Total . . . . . ▶ $ | | | | | | | | | | | | |

**Part III** **Grants or Assistance Benefiting Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of assistance | (d) Type of assistance | (e) Purpose of assistance |
|---|---|---|---|---|
| (1) | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |
| (5) | | | | |
| (6) | | | | |
| (7) | | | | |
| (8) | | | | |
| (9) | | | | |
| (10) | | | | |

**For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.**

**Part IV** **Business Transactions Involving Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

| | (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? Yes | No |
|---|---|---|---|---|---|---|
| (1) | NAUGATUCK VALLEY WOMENS HEALTH | DIRECTOR - M. ALBINI | 346,000. | SEE PART V FOR DESCRIPTIO | | X |
| (2) | WEBSTER FINANCIAL SERVICES | DIRECTOR - J. SMITH | 505,110. | SEE PART V FOR DESCRIPTIO | | X |
| (3) | | | | | | |
| (4) | | | | | | |
| (5) | | | | | | |
| (6) | | | | | | |
| (7) | | | | | | |
| (8) | | | | | | |
| (9) | | | | | | |
| (10) | | | | | | |

**Part V** **Supplemental Information**
Provide additional information for responses to questions on Schedule L (see instructions).

PART IV

DR. MARK ALBINI IS A MEMBER OF THE BOARD OF DIRECTORS OF SAINT MARY'S HOSPITAL, INC. DURING THE YEAR ENDING SEPTEMBER 30, 2014, THE HOSPITAL PAID DR. ALBINI'S PRACTICE, NAUGATUCK VALLEY WOMEN'S HEALTH, PC, $297,000 IN FEES FOR SERVICE. IN ADDITION, DR. ALBINI WAS PAID $49,000 BY SAINT MARY'S HOSPITAL FOR SERVICES PERFORMED DIRECTLY BY HIM FOR THE HOSPITAL.

MR. JAMES C. SMITH IS A MEMBER OF THE BOARD OF DIRECTORS OF SAINT MARY'S HEALTH SYSTEM, WHICH IS THE PARENT HOLDING COMPANY OF SAINT MARY'S HOSPITAL, INC. MR. SMITH IS ALSO THE CHAIRMAN OF WEBSTER BANK. THE HOSPITAL HAS A LINE OF CREDIT THROUGH WEBSTER BANK, THE BALANCE OF THE LINE OF CREDIT AT THE END OF THE REPORTING PERIOD WAS $0. DURING THE YEAR ENDED SEPTEMBER 30, 2014, THE HOSPITAL INCURRED $3,025 IN FEES ON THE LINE OF CREDIT AND PAID $116,016 IN BANKING FEES.

THE HOSPITAL ALSO PAYS WEBSTER FINANCIAL ADVISORS, A COMPANY RELATED TO THE WEBSTER BANK, TO ADMINISTER ITS PENSION PLAN AND OTHER INVESTMENT MANAGEMENT SERVICES. DURING THE YEAR ENDED SEPTEMBER 30, 2014, SAINT

**Part IV** **Business Transactions Involving Interested Persons.**
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

| | (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? Yes | No |
|---|---|---|---|---|---|---|
| (1) | | | | | | |
| (2) | | | | | | |
| (3) | | | | | | |
| (4) | | | | | | |
| (5) | | | | | | |
| (6) | | | | | | |
| (7) | | | | | | |
| (8) | | | | | | |
| (9) | | | | | | |
| (10) | | | | | | |

**Part V** **Supplemental Information**
Provide additional information for responses to questions on Schedule L (see instructions).

MARY'S HOSPITAL, INC. AND ITS AFFILIATES PAID $159,316 FOR INVESTMENT MANAGEMENT SERVICES AND $226,753 FOR AMINISTRATION OF THE HOSPITAL'S RETIREMENT PLAN ASSETS.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

# Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047
2013
Open to Public Inspection

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

990 PART III - LINE 4A

INPATIENT SERVICES SAINT MARY'S REMAINS COMMITTED TO PROVIDING THE HIGHEST QUALITY CARE FOR OUR PATIENTS. THE HOSPITAL PROVIDED INPATIENT TREATMENT FOR 11,698 INPATIENTS IN 2014, WITH AN AVERAGE LENGTH OF STAY OF 4.23 DAYS. SAINT MARY'S THREE LARGEST PROGRAMS ARE SURGERY, CARDIOLOGY AND MEDICINE.

IN 2014, 867 PATIENTS CHOSE TO HAVE GENERAL SURGERY AT SAINT MARY'S, STAYING AT THE HOSPITAL FOR A TOTAL OF 4,924 DAYS AND GENERATED $14 MILLION IN REVENUE; 1,354 PATIENTS CHOSE SAINT MARY'S FOR CARDIAC CARE, STAYING IN THE HOSPITAL FOR A TOTAL OF 5,854 DAYS AND GENERATING $19 MILLION IN REVENUE; AND 4,004 PATIENTS RECEIVED INPATIENT MEDICAL CARE, STAYING IN THE HOSPITAL FOR A TOTAL OF 19,158 DAYS, AND GENERATING $39 MILLION IN REVENUE.

AS THE HOSPITAL CONTINUES TO DISTINGUISH ITSELF AS A LEADING PROVIDER OF HEALTHCARE SERVICES IN THE REGION, IT HAS GARNERED RECOGNITION FROM STATE AND NATIONAL ORGANIZATIONS FOR PROVIDING OUTSTANDING PATIENT CARE.

SAINT MARY'S HOSPITAL IS RANKED AS THE TOP-PERFORMING HOSPITAL IN CONNECTICUT FOR DELIVERING PERCUTANEOUS CORONARY INTERVENTION (PCI), A LIFE-SAVING PROCEDURE THAT OPENS THE BLOCKED ARTERIES OF HEART ATTACK PATIENTS. THE NATIONAL STANDARD STATES THAT PATIENTS SHOULD RECEIVE THIS PROCEDURE WITHIN 90 MINUTES OF ARRIVAL AT THE HOSPITAL. ACCORDING TO THE

FEDERAL CENTERS FOR MEDICARE AND MEDICAID (CMS), 100 PERCENT OF PATIENTS WHO REQUIRE ANGIOPLASTY RECEIVE IT AT SAINT MARY'S WITHIN 90 MINUTES OF ARRIVAL. THIS RANKS SAINT MARY'S AS THE NUMBER ONE PERFORMING HOSPITAL IN CONNECTICUT, AND SIGNIFICANTLY AHEAD OF THE NATIONAL AVERAGE, WHICH IS 79 PERCENT OF PATIENTS BEING TREATED WITHIN 90 MINUTES.

IN ADDITION, SAINT MARY'S IS THE FIRST HOSPITAL IN CONNECTICUT TO RECEIVE A GOLD AWARD UNDER THE AMERICAN HEART ASSOCIATION'S GET WITH THE GUIDELINES PROGRAM FOR ITS TREATMENT OF PATIENTS WITH CORONARY ARTERY DISEASE. IT IS ALSO THE FIRST HOSPITAL IN THE STATE TO RECEIVE A GOLD AWARD FOR ITS TREATMENT OF PATIENTS WITH HEART FAILURE. AS OF FISCAL YEAR 2014, SAINT MARY'S HAS RECEIVED SIX GOLD AWARDS FOR CARDIAC CARE. THESE ACCOMPLISHMENTS ARE INDICATIVE OF THE EXTRAORDINARY CROSS-DISCIPLINE COLLABORATION AND OVERALL COMMITMENT TO CLINICAL EXCELLENCE SHARED BY THE SAINT MARY'S TEAM.

IN THE 2014 FISCAL YEAR, SAINT MARY'S ALSO ACHIEVED THE HIGHEST SCORES IN THEIR ESPECTIVE SIZE/GEOGRAPHIC GROUP EARNING THEM A SPOT ON THE CLEVERLY ASSOCIATES COMMUNITY VALUE 100 LIST FOR BEING A TOP VALUE HOSPITAL. IN ADDITION IN 2014, SAINT MARY'S WAS ONE OF ONLY 712 HOSPITALS IN THE UNITED STATES TO ACHIEVE THE TOP PERFORMER DISTINCTION TWO YEARS IN A ROW FROM THE JOINT COMMISSION.

IN ADDITION, SAINT MARY'S IS A LEADER IN SURGICAL SERVICES. OUR PHYSICIANS PROVIDE BOTH IN-PATIENT AND OUT-PATIENT SURGERY IN THE AREAS

OF GI, ONCOLOGY, THORACIC, VASCULAR, LAPAROSCOPY, TRAUMA, GYNECOLOGY, UROLOGY, NEUROSURGERY, ORTHOPEDICS, CARDIOTHORACIC, PLASTIC, BARIATRIC AND ENDOCRINE SURGERY AT SAINT MARY'S HOSPITAL.

OUR EXPERIENCED SURGEONS PERFORM ADVANCED ROBOTIC-ASSISTED PROCEDURES UTILIZING TWO DAVINCI® ROBOTIC SURGICAL SYSTEMS. THIS INNOVATIVE TECHNOLOGY IS BECOMING THE STANDARD OF CARE FOR MANY COMPLEX SURGICAL PROCEDURES WITH APPLICATIONS FOR GYNECOLOGIC, UROLOGIC, THORACIC, CARDIAC AND GENERAL SURGERY. AS THE LEADING PROVIDER OF SURGICAL SERVICES IN THE REGION, SAINT MARY'S IS COMMITTED TO PROVIDING THE HIGHEST QUALITY AND SUPERIOR SERVICE FOR OUR PATIENTS. DURING FISCAL YEAR 2014, SAINT MARY'S PERFORMED 653 SURGERIES USING THE DAVINCI® ROBOTIC SURGICAL SYSTEMS.

IN ADDITION, THE HOSPITAL OFFERS A COMPREHENSIVE SIX- YEAR TRAINING PROGRAM IN GENERAL SURGERY. SAINT MARY'S HOSPITAL IS COMMUNITY BASED AND BOASTS A CLOSE AFFILIATION TO YALE UNIVERSITY IN NEARBY NEW HAVEN, CONNECTICUT, AND THE UNIVERSITY OF CONNECTICUT IN FARMINGTON, CONNECTICUT. HISTORICALLY, NEARLY ONE HALF OF THE RESIDENTS COMPLETING THIS PROGRAM HAVE PURSUED FURTHER TRAINING IN CARDIOTHORACIC, COLON AND RECTAL, PLASTIC AND RECONSTRUCTIVE, SURGICAL ONCOLOGY, OR VASCULAR SURGERY.

990 PART III - LINE 4B

SAINT MARY'S HEALTH SYSTEM EXTENDS FROM WATERBURY TO WOLCOTT, NAUGATUCK, SOUTHBURY AND PROSPECT. IN 2014, 216,818 PATIENTS CHOSE SAINT MARY'S FOR OUTPATIENT CARE. THE HEALTH SYSTEM'S TWO LARGEST PROGRAMS ARE ITS

EMERGENCY DEPARTMENT, WHICH PROVIDED TREATMENT TO 62,335 PATIENTS IN 2014, GENERATING $26 MILLION IN REVENUE, AND AMBULATORY SURGERY. IN 2014, 14,313 PATIENTS CHOSE TO HAVE OUTPATIENT SURGERY AT SAINT MARY'S, GENERATING $47 MILLION IN REVENUE.

OUTPATIENT SERVICES INCLUDE BUT ARE NOT LIMITED TO: MEDICAL IMAGING, BLOOD DRAW AND LAB SERVICES, CARDIAC AND PULMONARY REHABILITATION CLASSES, NUTRITIONAL COUNSELING AND EXPECTANT PARENT CLASSES. SAINT MARY'S SATELLITE FACILITIES INCLUDE HEALTH AND WELLNESS CENTERS PROVIDING URGENT CARE, BLOOD DRAW STATIONS AND X-RAY SERVICES IN NAUGATUCK AND WOLCOTT; OUTPATIENT REHABILITATION THERAPY OFFICES IN WATERBURY, WOLCOTT AND NAUGATUCK; OUTPATIENT SLEEP DISORDERS CENTERS IN WATERBURY AND WOLCOTT; THE BREAST & ONCOLOGY CENTERS IN SOUTHBURY AND PROSPECT, AND OCCUPATIONAL THERAPY IN WATERBURY.

SAINT MARY'S HAS BEEN RECOGNIZED AT THE STATE AND NATIONAL LEVELS AS A DISTINGUISHED PROVIDER OF OUTPATIENT SERVICES.

ONE ADDITION TO THE OUTPATIENT SERVICES INCLUDED THE LIONS LOW VISION CENTER WHICH IS ONE OF ONLY FIVE CENTERS IN CONNECTICUT AND THE ONLY CETNER OF ITS KIND IN GREATER WATERBURY. SPECIALISTS COLLABORATE WITH PATIENTS' EYE CARE PROFESSIONLS AND HELP PATIENTS MAKE THE MOST OF THEIR AVAILABLE VISION WITH EXERCISES, COMPENSATORY STRATEGIES, AND TRAINING WITH LOW VISION AIDES.

SAINT MARY'S IS AMONG THE LARGEST AND BUSIEST EMERGENCY DEPARTMENTS IN THE STATE OF CONNECTICUT. IN FACT, WITH APPROXIMATELY 67,000 EMERGENCY VISITS PER YEAR, WE RANK AS THE 9TH BUSIEST IN THE STATE.

THE SAINT MARY'S EMERGENCY DEPARTMENTS IS A CERTIFIED LEVEL 2 TRAUMA CENTER, AND ALL PHYSICIANS ARE BOARD CERTIFIED IN EMERGENCY MEDICINE. THE EMERGENCY DEPARTMENT PLAYS A CRITICAL ROLE IN HELPING SAINT MARY'S ACHIEVE ITS EXTRAORDINARY PERFORMANCE WITH DOOR-TO-BALLOON TIME, A MEASURE OF THE TIME IT TAKES A HEART ATTACK VICTIM TO HAVE HIS OR HER BLOCKED ARTERIES OPENED. SAINT MARY'S MEDIAN DOOR-TO-BALLOON TIME IS 60 MINUTES. SAINT MARY'S DOOR-TO-BALLOON TIME IS 30 MINUTES FASTER THAN NATIONAL GUIDELINES SET BY THE AMERICAN COLLEGE OF CARDIOLOGY FOR OPENING BLOCKED ARTERIES.

THE DEPARTMENT ALSO PROVIDES AMBULATORY CARE SERVICES, WHICH ARE DESIGNED TO ACCOMMODATE NON-EMERGENT, LOWER ACUITY NEEDS. THIS UNIT CONTAINS A PEDIATRIC CENTER, WHICH IS STAFFED BY PEDIATRICIANS EACH AFTERNOON.

FINALLY, THE EMERGENCY DEPARTMENT CONTAINS A DEDICATED BEHAVIORAL HEALTH AREA, SUPPORTED BY A PSYCHIATRIST, SOCIAL WORKER AND SPECIALIZED NURSES. THIS UNIT PROVIDES A MUCH NEEDED RESOURCE FOR SERVING OUR PATIENT POPULATION, AND HAS SEEN CONTINUED GROWTH AND INCREASE IN DEMAND.

SAINT MARY'S CANCER PROGRAM WAS AWARDED A THREE-YEAR ACCREDITATION FROM THE AMERICAN COLLEGE OF SURGEONS' COMMISSION ON CANCER WITH COMMENDATION.

ONLY 40 PERCENT OF ALL U.S. HOSPITALS SURVEYED BY THE COMMISSION ACHIEVE THIS LEVEL OF RECOGNITION. ACS ACCREDITATION ENSURES THAT PATIENTS WHO CHOOSE SAINT MARY'S FOR CANCER CARE HAVE ACCESS TO A COMPLETE RANGE OF STATE-OF-THE-ART SERVICES AND EQUIPMENT, A TEAM THAT COORDINATES THE BEST AVAILABLE TREATMENT OPTIONS, AND ACCESS TO CLINICAL TRIALS AND NEW TREATMENT OPTIONS, AS WELL AS EARLY DETECTION PROGRAMS, EDUCATION AND SUPPORT SERVICES.

SAINT MARY'S WOUND HEALING CENTER IS STAFFED BY A SPECIALIZED TEAM OF PHYSICIANS, SURGEONS, NURSES AND TECHNICIANS, WHO COLLABORATE TO PRODUCE THE BEST POSSIBLE OUTCOMES. ON AVERAGE, 92.7 PERCENT OF PATIENTS WHO COME TO THE CENTER WITH CHRONIC WOUNDS THAT HAVE RESISTED TRADITIONAL TREATMENT ACHIEVE SUCCESSFUL RESULTS WITHIN 14 WEEKS. SPECIALIZED WOUND CARE ALSO HELPS PATIENTS WITH DIABETIC ULCERS, PRESSURE ULCERS, INFECTIONS AND COMPROMISED SKIN GRAFTS. IN ADDITION THE CENTER OFFERS HYPERBARIC OXYGEN THERAPY, WHICH IS PARTICULARLY EFFECTIVE FOR PATIENTS WHO SUFFER FROM RADIATION DAMAGE OR FACE THE POSSIBILITY OF AMPUTATION.

FORM 990, PART III

BUILDING UPON A LEGACY OF CARING THE MISSION OF SAINT MARY'S HOSPITAL IS TO PROVIDE EXCELLENT HEALTHCARE SERVICES IN A SPIRITUALLY ENRICHED ENVIRONMENT TO IMPROVE THE HEALTH OF OUR COMMUNITY.

IT IS THE HOSPITAL'S VISION TO BECOME AN INTEGRATED NETWORK OF HEALTHCARE PROVIDERS CREATING EXCEPTIONAL VALUE FOR THOSE WE SERVE THROUGH TRUSTED PARTNERSHIPS THAT EMPOWER AND TRANSFORM LIVES. THE HOSPITAL'S STAFF,

MEDICAL STAFF, BOARD OF DIRECTORS, FOUNDATION, AUXILIARY, AND VOLUNTEERS ARE ALSO UNITED BY THESE VALUES:

-INTEGRITY - COMMITMENT TO DOING WHAT IS RIGHT

- CARING - COMPASSIONATE APPROACH TO ADDRESSING THE HEALTHCARE NEEDS OF ALL PEOPLE

- ACCOUNTABILITY - PERSONAL RESPONSIBILITY FOR THE PERFORMANCE OF SAINT MARY'S HEALTH SYSTEM

- RESPECT - RESPECT FOR THE DIGNITY, WORTH, AND RIGHTS OF OTHERS

- EXCELLENCE - WORKING TOGETHER IN PURSUIT OF SUPERIOR CLINICAL QUALITY AND SERVICE TO OTHERS

990 PART VI SECTION A LINE 7A

SAINT MARY'S HEALTH SYSTEM, INC. IS THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC. AND APPOINTS THE BOARD OF DIRECTORS.

ARE THE DECISIONS OF THE GOVERNING BODY SUBJECT TO APPROVAL

990 PART VI SECTION A LINE 7B

PURSUANT TO THE PROVISIONS OF SECTION 33-1080(B) OF THE CONNECTICUT REVISED NON-STOCK CORPORATION ACT AND THE AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE CORPORATION, THERE SHALL BE RESERVED TO THE ARCHBISHOP OF THE HARTFORD ROMAN CATHOLIC ARCHDIOCESE OF HARTFORD (UNLESS SPECIFICALLY DELEGATED BY HIM) THE FOLLOWING RIGHTS AND POWERS: (A)TO APPROVE THE MISSION OR PURPOSE AND THE PHILOSOPHY OF THE CORPORATION AND OF ANY SAINT MARY'S SUBSIDIARIES. (B)TO APPROVE THE ACQUISITION, ALIENATION OR CONVEYANCE OF THE REAL PROPERTY OF THE CORPORATION THAT IS VALUED AT AN AMOUNT GREATER THAN THAT ESTABLISHED BY

THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS PURSUANT TO CANON LAW OR TO PLACE A MORTGAGE ON SUCH PROPERTY OR TO BORROW FUNDS IN AMOUNTS GREATER THAN THOSE ESTABLISHED BY THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS PURSUANT TO CANON LAW, WHETHER IN A SINGLE TRANSACTION OR A SERIES OF RELATED TRANSACTIONS. (C)TO APPROVE THE DISPOSAL OF ALL OR SUBSTANTIALLY ALL OF THE PHYSICAL ASSETS OF THE CORPORATION AND TO APPROVE THE MERGER OR CONSOLIDATION OF THE CORPORATION. (D)TO APPROVE THE AMENDMENT OF THE CERTIFICATE OF INCORPORATION OR THE BYLAWS OF THE CORPORATION.

PART VI, SECTION B, LINE 11A

THE FORM 990 WAS DISTRIBUTED TO BOARD MEMBERS AND THE ORGANIZATION'S FINANCE COMMITEE FOR THEIR REVIEW PRIOR TO FILING TO ENSURE ACCURACY AND COMPLETENESS. A COMPLETE COPY OF THE ORGANIZATION'S FINAL FORM 990, INCLUDING ALL REQUIRED SCHEDULES, AS ULTIMATELY FILED WITH THE IRS, WAS PROVIDED TO EACH MEMBER OF THE BOARD BEFORE ITS FILING WITH THE IRS.

990 PART VI - SECTION B - LINE 12C

ANNUALLY, EACH DIRECTOR, OFFICER, AND BOARD COMMITTEE MEMBER OF SMHS AND ANY OF ITS AFFILIATES, AS APPROPRIATE, WILL SIGN A STATEMENT WHICH AFFIRMS THAT THE PERSON:

1) HAS RECEIVED A COPY OF THE CONFLICT OF INTEREST POLICY;

2) HAS READ AND UNDERSTANDS THE POLICY; AND

3) HAS AGREED TO COMPLY WITH THE POLICY.

THE STATEMENTS WILL BE DISTRIBUTED ANNUALLY BY THE COMPLIANCE OFFICER AND RETURNED TO THE CEO OR DELEGATED PERSON, WHERE THEY WILL BE RECORDED, REVIEWED, SUMMARIZED AND PRESENTED TO THE CHAIRPERSON OF THE BOARD, AS WELL AS TO THE AUDIT AND GOVERNANCE COMMITTEES, WHERE THEY EXISTS. CONFLICT OF INTEREST STATEMENTS WILL BE MAINTAINED FOR A MINIMUM OF SEVEN YEARS BY THE COMPLIANCE OFFICER.

CONFLICT OF INTEREST FORMS PROVIDED BY OFFICERS, DIRECTORS AND BOARD COMMITTEE MEMBERS WILL BE FORWARDED TO THE COMPLIANCE OFFICER, ALONG WITH A STATEMENT OF IMPACT AS TO THE EFFECT OF THE CONFLICT OF INTEREST ON THE BUSINESS AND ANY ACTION TAKEN TO MINIMIZE THE EFFECT. THEY WILL BE MAINTAINED BY THE COMPLIANCE OFFICER FOR A MINIMUM OF SEVEN YEARS.

990 PART VI - SECTION B - LINES 15A & 15B

THE PROCESS FOR DETERMINING THE COMPENSATION OF THE HOSPITAL'S TOP MANAGEMENT OFFICIALS, INCLUDING THE CEO, ALL OFFICERS, AND KEY EMPLOYEES, MEET THE THREE REQUIREMENTS OF THE REBUTTABLE PRESUMPTION. THE COMPENSATION ARRANGEMENT IS APPROVED IN ADVANCE BY THE ORGANIZATION'S EXECUTIVE COMPENSATION COMMITTEE. THE COMMITTEE IS APPOINTED BY THE BOARD OF DIRECTORS FOR THE PURPOSE OF ASSISTING THE BOARD TO FULFILL ITS RESPONSIBILY TO THE HOSPITAL AND THE COMMUNITY TO ENSURE THE COMPENSATION IS IN ACCORDANCE WITH THE HOSPITAL'S POLICIES. THE COMMITTEE IS COMPRISED OF SIX DIRECTORS WHO ARE INDEPENDENT OF MANAGEMENT AND THE HOSPITAL AND FREE OF ANY CONFLICTS OF INTEREST THAT WOULD INTERFERE WITH THEIR EXERCISE OF INDEPENDENT JUDGEMENT. PRIOR TO MAKING ANY COMPENSATION DECISIONS, THE EXECUTIVE COMPENSATION COMMITTEE OBTAINED AND

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

RELIED UPON APPROPRIATE DATA AS TO COMPARABILITY. THE COMMITTEE CONTRACTS AN INDEPENDENT COMPENSATION CONSULTANT AND UTILIZES LOCAL AND NATIONAL COMPENSATION SURVERY'S TO SET COMPENSATION LEVELS. FINALLY, THE EXECUTIVE COMPENSATION COMMITTEE ADEQUATELY AND TIMELY DOCUMENTED THE BASIS FOR SETTING COMPENSATION CONCURRENTLY WITH THE MAKING OF THE DETERMINATION.

PART VI, SECTION C, QUESTION 19

COPIES OF THE GOVERNING DOCUMENTS, CONFLICTS OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

PART XI, LINE 9

| | |
|---|---|
| TRANSFERS TO AFFILIATES | ($14,778,000) |
| MINIMUM PENSIONS LIAB CHANGE | ($13,377,000) |
| CHANGE IN FOUNDATION INTEREST | $ 351,580 |
| NET ADDITIONS TO ASSETS HELD IN TRUST | $ 426,000 |
| OTHER | ($ 47,173) |
| TOTAL | ($27,424,593) |

ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

| NAME AND ADDRESS | DESCRIPTION OF SERVICES | COMPENSATION |
|---|---|---|
| SODEXHO INC. & AFFILIATES<br>PO BOX 905374<br>CHARLOTTE, NC 28290 | HOSPITAL MGMT SVCS | 3,285,079. |

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

ATTACHMENT 1 (CONT'D)

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

| NAME AND ADDRESS | DESCRIPTION OF SERVICES | COMPENSATION |
|---|---|---|
| MIDDLE CT EMERGENCY PHYSICIANS<br>1000 RIVER ROAD, SUITE 100<br>CONSHOHOCKEN, PA 19428 | EMERGENCY ROOM SVCS | 2,825,989. |
| PRECYSE SOLUTIONS LLC<br>PO BOX 11407<br>BIRMINGHAM, AL 35246 | CONTRACT LABOR SVCS | 3,886,995. |
| FINANCIAL HEALTH STRATEGIES<br>704 QUINCE ROAD, SUITE 300<br>GAITHERSBURG, MD 20878 | CONTRACT LABOR SVCS | 1,449,472. |
| ANTHELIO<br>ONE FINANCIAL CENTER<br>BOSTON, MA 02111 | HOSP MGMT/IT HOSTING | 2,599,856. |

ATTACHMENT 2

FORM 990, PART VIII - INVESTMENT INCOME

| DESCRIPTION | (A) TOTAL REVENUE | (B) RELATED OR EXEMPT REVENUE | (C) UNRELATED BUSINESS REV. | (D) EXCLUDED REVENUE |
|---|---|---|---|---|
| MRI PARTNERSHIP INCOME | -55,484. | | | -55,484. |
| DIAGNOSTIC IMAGING CENTER INCOME | 646,709. | | | 646,709. |
| PREMIER INCOME | 667,720. | | -4,499. | 672,219. |
| HLRCC JV NET INCOME | -423,587. | | | -423,587. |
| DIVIDEND & INTEREST REVENUE | 2,931,875. | | | 2,931,875. |
| TOTALS | 3,767,233. | | -4,499. | 3,771,732. |

ATTACHMENT 3

Name of the organization: ST. MARY'S HOSPITAL, INC.

Employer identification number: 06-0646844

ATTACHMENT 3 (CONT'D)

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

| DESCRIPTION | | BEGINNING BOOK VALUE | ENDING BOOK VALUE | COST OR FMV |
|---|---|---|---|---|
| MARKETABLE SECURITIES | | 18,505,914. | 20,802,742. | FMV |
| | TOTALS | 18,505,914. | 20,802,742. | |

**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: ST. MARY'S HOSPITAL, INC.
Employer identification number: 06-0646844

**Part I** **Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|---|---|---|---|---|
| (1) ST. MARY'S INDEMNITY COMPANY, LLC 06-0646844<br>126 COLLEGE STREET BURLINGTON, VT 05401 | INSURANCE | VT | 2,523,000. | 46,719,000. | ST MARY HOSP |
| (2) ST. MARY'S PHYSICIAN PARTNERS, LLC 46-5760769<br>56 FRANKLIN STREET WATERBURY, CT 06706 | ACCOUNT. CARE | CT | 0 | 0 | ST MARY HOSP |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |

**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 | No |
|---|---|---|---|---|---|---|---|
| (1) ST. MARY'S HEALTH SYSTEM, INC. 22-2528399<br>56 FRANKLIN STREET WATERBURY, CT 06703 | HOLDING CO. | CT | 501(C)(3) | 11B | N/A | | X |
| (2) SAINT MARY'S FOUNDATION 22-2528400<br>56 FRANKLIN STREET WATERBURY, CT 06703 | FUNDRAISING | CT | 501(C)(3) | 7 | ST MARY HOSP | X | |
| (3) HAROLD LEEVER REGIONAL CANCER CENTER 06-1548409<br>1075 CHASE PARKWAY WATERBURY, CT 06708 | TREATMENT CTR | CT | 501(C)(3) | 3 | ST MARY HOSP | X | |
| (4) HEART CENTER OF GREATER WATERBURY, INC. 83-0416893<br>P.O. BOX 2153 WATERBURY, CT 06722 | MANAGEMENT | CT | 501(C)(3) | 11A | ST MARY HOSP | X | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2013

JSA
3E1307 1.000



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**Part III** **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? Yes | (h) No | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? Yes | (j) No | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (1) DIAGNOSTIC IMAGING OF SOUTHBUR 385 MAIN STREET SOUTH | IMAGING CENTER | CT | N/A | RELATED | 735,013. | 1,412,020. | | X | 0 | | | 60.0000 |
| (2) | | | | | | | | | | | | |
| (3) | | | | | | | | | | | | |
| (4) | | | | | | | | | | | | |
| (5) | | | | | | | | | | | | |
| (6) | | | | | | | | | | | | |
| (7) | | | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|
| (1) FRANKLIN MEDICAL GROUP, PC 06-1470493 56 FRANKLIN STREET WATERBURY, CT 06706 | PHYSICIAN OFF | CT | N/A | C CORP | -12,810,000. | 5,492,000. | 100.0000 | X | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| (5) | | | | | | | | | |
| (6) | | | | | | | | | |
| (7) | | | | | | | | | |

**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) | FRANKLIN MEDICAL GROUP, PC | B | 14,281,747. | FMV |
| (2) | FRANKLIN MEDICAL GROUP, PC | M | 2,961,355. | FMV |
| (3) | DIAGNOSTIC IMAGING OF SOUTHBURY, LLC | S | 546,000. | FMV |
| (4) | ST. MARY'S HOSPITAL FOUNDATION, INC. | C | 75,420. | FMV |
| (5) | FRANKLIN MEDICAL GROUP, PC | O | 495,431. | FMV |
| (6) | | | | |

**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 section 501(c)(3) organizations? | | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Yes | No | | | Yes | No | | Yes | No | |
| (1) | | | | | | | | | | | | | |
| (2) | | | | | | | | | | | | | |
| (3) | | | | | | | | | | | | | |
| (4) | | | | | | | | | | | | | |
| (5) | | | | | | | | | | | | | |
| (6) | | | | | | | | | | | | | |
| (7) | | | | | | | | | | | | | |
| (8) | | | | | | | | | | | | | |
| (9) | | | | | | | | | | | | | |
| (10) | | | | | | | | | | | | | |
| (11) | | | | | | | | | | | | | |
| (12) | | | | | | | | | | | | | |
| (13) | | | | | | | | | | | | | |
| (14) | | | | | | | | | | | | | |
| (15) | | | | | | | | | | | | | |
| (16) | | | | | | | | | | | | | |

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**Part VII** **Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

KPMG

# SAINT MARY'S HOSPITAL, INC.

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

(With Independent Auditors' Report Thereon)

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Financial Statements and
Consolidating Information

September 30, 2014 and 2013

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

# Independent Auditors' Report

The Board of Directors
Saint Mary's Hospital, Inc.:

We have audited the accompanying consolidated financial statements of Saint Mary's Hospital, Inc. (the Hospital), as of September 30, 2014 and 2013, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations, 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 U.S. generally accepted accounting principles; 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 require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on 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 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 Saint Mary's Hospital, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

*Other Matter*

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Exhibits 1 and 2 is presented for 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 audit 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 as a whole.

KPMG LLP

December 22, 2014

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Balance Sheets

September 30, 2014 and 2013

(In thousands)

| Assets | | 2014 | 2013 |
|---|---|---|---|
| Current assets: | | | |
| Cash and cash equivalents | $ | 25,797 | 28,902 |
| Short-term investments | | 17 | 29 |
| Current portion of assets whose use is limited | | 5,948 | 8,039 |
| Accounts receivable, net of estimated uncollectibles of $8,975 in 2014 and $9,392 in 2013 | | 30,196 | 30,730 |
| Other current assets | | 6,612 | 4,357 |
| Total current assets | | 68,570 | 72,057 |
| Marketable securities | | 20,803 | 18,506 |
| Assets whose use is limited: | | | |
| By donor and held in trust by others | | 15,696 | 15,258 |
| For estimated self-insurance liability | | 41,038 | 31,394 |
| By bond indenture | | 4,321 | 4,324 |
| Net interest in Foundation | | 5,182 | 4,874 |
| Other | | 6 | 6 |
| Total assets whose use is limited | | 66,243 | 55,856 |
| Less current portion of assets whose use is limited | | 5,948 | 8,039 |
| Noncurrent assets whose use is limited | | 60,295 | 47,817 |
| Property and equipment, net | | 62,371 | 63,874 |
| Other assets: | | | |
| Investments in joint venture arrangements | | 10,024 | 10,697 |
| Deferred financing costs, net | | 103 | 128 |
| Total other assets | | 10,127 | 10,825 |
| Total assets | $ | 222,166 | 213,079 |
| **Liabilities and Net Assets** | | | |
| Current liabilities: | | | |
| Current portion of long-term obligations | $ | 2,509 | 2,490 |
| Accounts payable | | 17,252 | 20,899 |
| Salaries, wages, and payroll withholdings | | 5,643 | 4,734 |
| Due to third-party payors, net | | 783 | 6,035 |
| Accrued expenses and other current liabilities | | 14,308 | 16,486 |
| Total current liabilities | | 40,495 | 50,644 |
| Long-term liabilities: | | | |
| Long-term obligations, net of current portion | | 17,891 | 20,374 |
| Estimated self-insurance liability | | 31,814 | 21,908 |
| Pension and deferred compensation | | 72,182 | 58,823 |
| Other long-term liabilities | | 9,523 | 10,172 |
| Total long-term liabilities | | 131,410 | 111,277 |
| Net assets: | | | |
| Unrestricted Hospital | | 30,795 | 32,332 |
| Noncontrolling interest in subsidiaries | | 370 | 302 |
| Total unrestricted | | 31,165 | 32,634 |
| Temporarily restricted | | 2,415 | 2,269 |
| Permanently restricted | | 16,681 | 16,255 |
| Total net assets | | 50,261 | 51,158 |
| Total liabilities and net assets | $ | 222,166 | 213,079 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Statements of Operations

Years ended September 30, 2014 and 2013

(In thousands)

| | 2014 | 2013 |
|---|---|---|
| Revenues: | | |
| Revenue from patient services, net of contractual allowances | $ 279,161 | 268,899 |
| Provision for uncollectible accounts, net of recoveries | (11,074) | (12,878) |
| Net revenue from patient services | 268,087 | 256,021 |
| Other operating revenues | 9,776 | 6,871 |
| Total revenues | 277,863 | 262,892 |
| Expenses: | | |
| Salaries and wages | 113,207 | 108,642 |
| Employee benefits | 28,620 | 31,294 |
| Supplies and other expenses | 115,262 | 103,072 |
| Depreciation and amortization | 10,455 | 9,977 |
| Interest | 1,438 | 1,594 |
| Total expenses | 268,982 | 254,579 |
| Operating income | 8,881 | 8,313 |
| Nonoperating gains (losses): | | |
| Investment income, net | 3,824 | 2,390 |
| Equity in earnings of joint ventures | 189 | 1,170 |
| Change in net assets of Foundation | 281 | 437 |
| Net loss on disposal of assets | (46) | (230) |
| Other | (283) | (1,572) |
| Total nonoperating gains, net | 3,965 | 2,195 |
| Excess revenues over expenses | 12,846 | 10,508 |
| Net assets released from restriction for capital expenditures | (48) | 545 |
| Capital transactions with affiliates | (363) | (519) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | (527) | 401 |
| Change in accumulated pension charges to unrestricted net assets | (13,377) | 20,819 |
| (Decrease) increase in unrestricted net assets | $ (1,469) | 31,754 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Statements of Changes in Net Assets

Years ended September 30, 2014 and 2013

(In thousands)

| | 2014 | 2013 |
|---|---|---|
| Unrestricted net assets: | | |
| Excess of revenues over expenses | $ 12,846 | 10,508 |
| Net assets released from restriction for capital expenditures | (48) | 545 |
| Capital transactions with affiliates | (363) | (519) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | (527) | 401 |
| Change in accumulated pension charges to unrestricted net assets | (13,377) | 20,819 |
| (Decrease) increase in unrestricted net assets | (1,469) | 31,754 |
| Temporarily restricted net assets: | | |
| Change in net assets of Foundation | 146 | (100) |
| Change in net assets of Cancer Center, including releases for capital expenditures | — | (177) |
| Increase (decrease) in temporarily restricted net assets | 146 | (277) |
| Permanently restricted net assets: | | |
| Net earnings on assets held in trust by others | 1,177 | 1,653 |
| Appropriation for expenditure | (751) | (704) |
| Increase in permanently restricted net assets | 426 | 949 |
| (Decrease) increase in net assets | (897) | 32,426 |
| Net assets – beginning of year | 51,158 | 18,732 |
| Net assets – end of year | $ 50,261 | 51,158 |

See accompanying notes to consolidated financial statements.

**SAINT MARY'S HOSPITAL, INC.**

Consolidated Statements of Cash Flows

Years ended September 30, 2014 and 2013

(In thousands)

| | 2014 | 2013 |
|---|---|---|
| Cash flows from operating activities: | | |
| (Decrease) increase in net assets | $ (897) | 32,426 |
| Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities: | | |
| Depreciation and amortization | 10,480 | 10,003 |
| Net loss on disposal of assets | 46 | 230 |
| Change in unrealized losses (gains) on investments | 527 | (401) |
| Change in net interest in Foundation | (308) | (379) |
| Change in net assets of Cancer Center | — | 177 |
| Change in accumulated pension charges to unrestricted net assets | 13,377 | (20,819) |
| Change in permanently restricted net assets | (426) | (949) |
| Investment income, net | (3,824) | (2,390) |
| Equity in earnings of joint ventures | (189) | (1,170) |
| (Increase) decrease in operating assets: | | |
| Accounts receivable, net | 534 | 3,287 |
| Other current assets | (2,255) | 125 |
| Increase (decrease) in operating liabilities: | | |
| Due to third-party payors, net | (5,252) | (972) |
| Accounts payable and other current liabilities | (6,702) | 1,522 |
| Estimated self-insurance liability | 9,906 | 2,846 |
| Pension, deferred compensation, and other long-term liabilities | (667) | 526 |
| Net cash provided by operating activities | 14,350 | 24,062 |
| Cash flows from investing activities: | | |
| Purchases of property and equipment | (7,212) | (15,479) |
| Distributions from joint ventures | 546 | 420 |
| Investments in joint venture arrangements | 316 | 272 |
| Change in other assets whose use is limited | (6,258) | 106 |
| Change in assets held in trust by others | 426 | 949 |
| Net decrease in investments | (2,812) | (2,052) |
| Net cash used in investing activities | (14,994) | (15,784) |
| Cash flows from financing activities: | | |
| Change in assets whose use is limited by bond indenture | 3 | (224) |
| Payments on long-term obligations | (2,464) | (1,676) |
| Net cash used in financing activities | (2,461) | (1,900) |
| Net (decrease) increase in cash and cash equivalents | (3,105) | 6,378 |
| Cash and cash equivalents – beginning of year | 28,902 | 22,524 |
| Cash and cash equivalents – end of year | $ 25,797 | 28,902 |
| Supplemental disclosure of cash flow information: | | |
| Cash paid during the year for interest | $ 1,402 | 1,558 |
| Supplemental disclosure of noncash item: | | |
| Assets acquired under capital lease | $ — | 600 |

See accompanying notes to consolidated financial statements.

## (1) Organization

Saint Mary's Hospital, Inc. (the Hospital) is an acute care hospital located in Waterbury, Connecticut. The Hospital was founded in 1907 and is licensed for 347 beds and 32 newborn bassinets. The Hospital currently staffs 168 beds and 20 newborn bassinets. The Hospital provides a broad range of inpatient and outpatient services including a number of medical and surgical specialties, obstetrics, pediatrics, mental health, alcohol and substance abuse rehabilitation (outpatient) and off-site ambulatory services.

The Hospital's parent holding company is Saint Mary's Health System, Inc. (SMHS). Saint Mary's Hospital Foundation, Inc. (the Foundation) was organized to raise funds to support the Hospital. SMHS is the sole member of the Hospital and the Foundation.

The Hospital has four consolidated subsidiaries: Franklin Medical Group, P.C. (Franklin), a for-profit Connecticut corporation; Saint Mary's Indemnity Company, LLC (the Indemnity Company) a Vermont limited liability company; Diagnostic Imaging of Southbury, LLC (the Diagnostic Center), a for-profit Connecticut corporation and Saint Mary's Physician Partners, LLC (Physician Partners) a Connecticut limited liability company.

The Indemnity Company was formed during June 2009 to provide professional and general liability insurance to the Hospital, Franklin, and community physicians.

The Hospital has a 60% equity interest in the Diagnostic Center, which provides diagnostic imaging services. The remaining interest is accounted for as noncontrolling interest in the accompanying consolidated financial statements.

Physician Partners was formed during July 2014 as a Medicare Shared Savings Plan (MSSP) Accountable Care Organization (ACO). The company had no activity in fiscal year 2014 and; therefore is not included in the consolidating schedules.

The assets, liabilities and operations of the Hospital's Auxiliary have not been reflected in the accompanying consolidated financial statements. Such amounts are not considered significant to the Hospital's consolidated financial position or results of its operations.

## (2) Community Benefit (Unaudited)

The Hospital is a community teaching hospital that serves the healthcare needs of the Central Naugatuck Valley area. Like other healthcare providers across the nation, the Hospital is faced with the challenge of serving those in need with fewer resources. Although the Hospital cannot meet community needs alone, it is committed to seek out unmet community needs and to be a catalyst in efforts to ensure an adequate community-wide response from government and public organizations in fulfilling community needs.

### *(a) Charity and Uncompensated Care*

As part of fulfilling its mission, the Hospital provides care to all patients in need, regardless of their ability to pay. The Hospital has a formalized charity care policy that identifies which patients are deemed "charity care". During 2014 and 2013, the costs associated with the charges foregone, measured using a ratio of cost to charge, related to charity care were approximately $328,000 and $94,000, respectively.

Many patients without insurance do not complete the application for charity care. The Hospital, upon performing an asset verification, makes a determination whether the patient would have qualified for the charity care. During 2012, the costs associated with the charges foregone related to these patients were approximately $1,340,000. During 2013, a system conversion limited the Hospital's ability to undertake an asset verification. As such, these costs are classified in the provision for uncollectible accounts. The Hospital implemented a solution at the end of fiscal year 2014, which will allow the Hospital to perform these types of verifications. The Hospital believes that had it performed the asset verifications throughout the fiscal year, costs associated with these patients for fiscal year 2014 and 2013 would have been fairly consistent with fiscal year 2012.

In addition, the Hospital provides care to patients covered by governmental healthcare programs. During 2014 and 2013, the Hospital estimates that the cost of providing this care exceeded compensation by $11,082,000 and $11,336,000, respectively.

*(b)* ***Education, Research and Training***

As a community teaching hospital affiliated with Yale School of Medicine, the Hospital has residency programs for general surgery, internal medicine and dental. These programs educate in excess of 50 residents and medical students per year. In addition to its residency programs, the Hospital furthers its educational mission by offering allied health programs affiliated with area educational facilities.

*(c)* ***Wellness and Health Promotional Activities***

The Hospital provides many activities to promote the concept of healthy lifestyles, including the publishing and free distribution of *Thrive*, which reaches more than 30,000 community households, health risk screenings, health fairs, support groups, a web-based physician search tool, and a health content library available via the Hospital's website (www.stmh.org).

*(d)* ***Leadership, Advocacy and Voluntarism***

The Hospital's employees are responsive to the community in the areas of planning, governance and service by annually providing thousands of hours of volunteer services, participating on boards of directors and advisory councils, testifying before public policy bodies and working with other healthcare organizations to develop healthcare policies for all persons. The Hospital also provides volunteer opportunities for community residents. The Hospital recognizes donated goods and services at their appraised or estimated value if they create or enhance nonfinancial assets or require specialized skills and would typically be purchased if not provided by donation. The volunteer services the Hospital received do not meet this criteria for recognition in the accompanying consolidated financial statements, but the volunteers donate a significant amount of time to the Hospital. In fiscal years 2014 and 2013, approximately 171 and 168 volunteers spent more than 21,100 hours and 20,400 hours, respectively, of service in Hospital departments.

*(e)* ***Dollar, Time and In-kind Donations***

The Hospital also provides services to neighborhood schools and organizations at no cost. Contributions are made to programs, organizations and foundations for efforts on behalf of the poor, the disadvantaged and the general population. The Hospital also provides a variety of in-kind

(Continued)

services including education on parenting and child abuse prevention and use of Hospital space for community meetings.

*(f) Other Support Services*

The Hospital provides outreach and social support services to patients. Programs such as the Sleep Disorders Support Group and the Chronic Lung Disorders/Pulmonary Support Group are integral to the healing of patients, and represent the Hospital's overall commitment to the continuum of care.

## (3) Summary of Significant Accounting Policies

*(a) Basis of Presentation*

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles. All intercompany transactions have been eliminated in consolidation.

*(b) Patient Service Revenue*

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. 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.

*(c) Charity Care and Provision for Uncollectible Accounts*

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators.

*(d) Cash and Cash Equivalents*

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

The Hospital invests its surplus operating funds in overnight repurchase agreement investments. These investments are collateralized with securities issued by the United States Government or its agencies and are not covered by FDIC insurance.

### (e) *Assets Whose Use is Limited*

Assets whose use is limited primarily include assets held by others pursuant to donor restrictions, by trustees under indenture agreements, and by a wholly owned captive insurance company for professional and general liability insurance.

### (f) *Marketable Securities*

Investments in equity securities, mutual funds and all investments in debt securities are reported at fair value based on readily determinable fair market values or estimated fair value in the accompanying consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities or are considered to be other than temporarily impaired.

The Hospital has followed a policy of reviewing all investments that have been below cost by at least 25% for three quarters. Unless specific evidence exists to the contrary, the adjustments of these investments to fair value (i.e. new cost basis) is reflected as an other than temporary impairment. The Hospital recorded $46,000 and $43,000 of other than temporary impairments on investments in 2014 and 2013, respectively, which are included in investment income, net in the accompanying consolidated statements of operations.

Investment securities, in general, are exposed to various risks. Recent market conditions have resulted in an unusually high degree of volatility and increased the risks and short term liquidity of certain investments held by the Hospital which could impact the value of investments after the date of these consolidated financial statements.

### (g) *Property and Equipment*

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Costs for repairs and maintenance are expensed as incurred.

Gifts of long-lived assets are reported as unrestricted support, and are excluded from the excess (deficiency) of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restriction that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Hospital reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset exceeds its fair value and may not be recoverable.

### *(h) Investments in Joint Venture Arrangements*

Investments in joint venture arrangements, generally in the form of partnership interests, are accounted for using the equity method of accounting.

### *(i) Fair Value of Financial Instruments*

FASB ASC 820 establishes a framework for measuring fair value which provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

- *Level 1* – Inputs into the valuation methodology are the unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.
- *Level 2* – Inputs into the valuation methodology include quoted prices for similar assets or liabilities in active and inactive markets, other than quoted prices that are observable for specific assets or liabilities, and values that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified contractual term, the value must be observable for substantially the full term of the asset or liability.
- *Level 3* – Inputs into the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital owns an interest in the trust rather than in the securities underlying the trust, and therefore it is generally required to consider such investments as Level 3 for the purposes of applying ASC 820. Such classification is based on the inability to redeem the investment, even though the underlying securities may not be difficult to value or may be readily marketable. Accordingly, the inputs or methodology used for valuing or classifying investments for financial reporting purposes are not necessarily an indication of the risk associated with investing in those investments.

The methods described above may produce a fair value that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The carrying amount of patient accounts receivable, accounts payable, and accrued expenses approximate fair value because of the short maturity of these accounts.

### *(j) Net Interest in Foundation*

The Hospital recognizes an asset for its interest in the net assets of the Foundation, which is a financially interrelated recipient organization, as defined. The change in the Foundation's net assets during 2014 and 2013 is shown separately in the accompanying consolidated statements of operations and changes in net assets. The Hospital's interest is classified as net interest in Foundation on the accompanying consolidated balance sheets.

### *(k) Net Asset Categories*

To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

*Unrestricted* – Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the board of directors for future capital improvements or for other purposes, as deemed appropriate.

*Temporarily Restricted* – Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

*Permanently Restricted* – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that only the income earned that the trustee does not reinvest be available for operations. The net appreciation of the value of investments held in trust by others remains in permanently restricted net assets until cash is transferred to the Hospital.

### *(l) Excess of Revenues over Expenses*

Excess of revenues over expenses included in the consolidated statements of operations reflects the Hospital's performance measure. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, and 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). Nonoperating gains and losses and equity in earnings of joint ventures are considered in the performance measure.

### *(m) Income Taxes*

The Hospital is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code and is generally exempt from income taxes. The accompanying consolidated financial statements have been prepared on the basis that this tax-exempt status will be maintained.

Franklin is a for-profit organization subject to income taxes. Franklin has net operating loss carryforwards. A valuation allowance has been recorded as management believes realization of such carryforwards is doubtful.

The Diagnostic Center is a pass-through entity. The Indemnity Company and Physician Partners are disregarded entities. The tax consequences of their operating results are assessed at the member level.

The Hospital recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in recognition in measurement are reflected in the period in which the change in judgment occurs. The Hospital did not recognize the effect of any income tax positions in either 2014 or 2013.

### *(n) Use of Estimates*

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingencies at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Financial statement areas where management applies the use of assumptions and estimates consist primarily of the allowance for uncollectible accounts, contractual allowances and related third-party accounts, the pension liability, and the estimated self-insurance liability.

### *(o) Professional and General Liability*

The liability for unpaid losses and loss adjustment expenses includes estimates for reported losses, plus supplemental amounts calculated based upon loss projections utilizing the Indemnity Company's and insureds' historical data. In establishing this reserve, the Indemnity Company utilizes the findings of an independent consulting actuary. Management believes that its aggregate liability for unpaid losses and loss adjustment expenses at year-end represents its best estimate, based upon available data, of the amount necessary to cover the ultimate cost of losses.

The ultimate liability and receivable could be significantly in excess of or less than the amount indicated in the consolidated financial statements. As adjustments to these estimates become necessary, such adjustments will be reflected in current operations.

### *(p) Recently Issued Accounting Pronouncements*

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, *Health Care Entities* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07), which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. ASU 2011-07 was effective for the Hospital's fiscal

year beginning October 1, 2012, and the change in presentation did not significantly impact the Hospital's financial position, results of operations or cash flows.

*(q) Prior Year Reclassifications*

Certain prior year balances have been reclassified in order to be consistent with the current year presentation.

## (4) Net Revenue from Patient Services

A substantial portion of net revenue from patient services is derived from funds provided on behalf of patients under federal and state medical assistance programs. Revenue from some of these sources is determined by the application of reimbursement principles and is subject to audit by the applicable agencies. In the opinion of management, such principles have been properly applied in the determination of net patient service revenue. Settlement notices have been received from the Medicare program and the Medicaid program through 2010 and 2000, respectively. 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 or as years are no longer subject to audits, reviews and investigations. Adjustments related to prior year estimates increased the Hospital's net revenues by approximately $5,977,000 and $3,775,000, respectively.

Net patient service revenues consist of inpatient revenues, principally from routine patient care and ancillary services and outpatient revenues from ancillary services, after considering allowances under agreements with various third-party payors and provisions for uncollectible accounts. A reconciliation of gross revenues to net revenues from patient services for the years ended September 30, 2014 and 2013, is as follows (in thousands):

| | 2014 | 2013 |
|---|---|---|
| Gross revenue from patient services | $ 733,919 | 670,163 |
| Contractual and other allowances | (454,430) | (401,170) |
| Charity care | (328) | (94) |
| Provision for uncollectible accounts, net of recoveries | (11,074) | (12,878) |
| Net revenue from patient services | $ 268,087 | 256,021 |



(Continued)

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of discounted rates based on the self-pay discount policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

| | | Governmental and other third-party payors | Self-pay | Total all payors |
|---|---|---|---|---|
| Revenue from patient services, net of contractual allowances, as of September 30, 2014 | $ | 271,936 | 7,225 | 279,161 |
| Revenue from patient services, net of contractual allowances, as of September 30, 2013 | $ | 257,527 | 11,372 | 268,899 |

The Hospital grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of gross receivables from private pay patients and third-party payors at September 30, 2014 and 2013 was as follows:

| | 2014 | 2013 |
|---|---|---|
| Medicare (including Medicare managed care) | 31.6% | 31.9% |
| Medicaid | 12.3 | 13.1 |
| Other third-party payors | 32.5 | 33.1 |
| Private pay patients | 23.6 | 21.9 |
| | 100.0% | 100.0% |

The Hospital's exposure to risk of nonpayment from private pay patients is more significant than other payors. However, the Hospital has recorded an estimate for uncollectible accounts, which, in management's opinion, is sufficient to provide for such risk. This estimate is based on a variety of factors including historical experience, the current economic environment and recent payment patterns.

## (5) Regulatory and Legislative Matters

### *(a) State of Connecticut Regulatory Environment*

Connecticut's acute care hospital regulatory system is currently administered by the State of Connecticut Office of Health Care Access (OHCA). The Hospital is subject to a regulatory system that includes the administration of a pool resulting in distribution of monies by the State to the Hospital.

The Hospital is subject to legislation enacted in 2011 imposing a tax on certain net patient service revenues of hospitals and changes to the disproportionate share hospital payments (DSH) pursuant to 2011 Conn. Pub. Acts 6 (145-149), as amended by 2011 Conn. Pub. Acts 44 (102-103) and Conn. Pub. Acts 61 (79). The tax is paid on a quarterly basis. The Hospital recorded a tax of $8,789,076 which has been offset with $7,559,854 of DSH payments and is recorded in supplies and other expenses for the year ended September 30, 2014. The Hospital recorded a tax of $8,789,076 which has been offset with $8,748,914 of DSH payments and is recorded in net revenue from patients for the year ended September 30, 2013.

### (b) *Federal Regulatory Environment*

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 and security and privacy of health information. Government activity has increased 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. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, 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.

## (6) Marketable Securities and Assets Whose Use is Limited

A comparison of cost and fair values of short-term investments, marketable securities, and assets whose use is limited, including the fair value of investments with unrealized losses that are not deemed other-than-temporarily impaired and the length of time the individual securities have been in a continuous unrealized loss position, at September 30, 2014 and 2013, is as follows (in thousands):

| | 2014 | | | | | |
|---|---|---|---|---|---|---|
| | Total | | Less than 12 months | | 12 months or more | |
| | Fair value | Cost | Fair value | Unrealized losses | Fair value | Unrealized losses |
| Cash and cash equivalents | $ 18,630 | 18,630 | — | — | — | — |
| Corporate bonds | 11,820 | 11,807 | 1,062 | (18) | 4,559 | (162) |
| U.S. government and agency obligations | 14,023 | 13,990 | 2,926 | (16) | 1,686 | (34) |
| Mutual funds | 25,357 | 21,016 | 608 | (9) | — | — |
| Equities | 1,145 | 1,173 | 605 | (62) | — | — |
| | $ 70,975 | 66,616 | 5,201 | (105) | 6,245 | (196) |



(Continued)

| | 2013 | | | | | |
|---|---|---|---|---|---|---|
| | Total | | Less than 12 months | | 12 months or more | |
| | Fair value | Cost | Fair value | Unrealized losses | Fair value | Unrealized losses |
| Cash and cash equivalents | $ 2,671 | 2,671 | — | — | — | — |
| Corporate bonds | 15,083 | 15,885 | 4,668 | (274) | 734 | (53) |
| U.S. government and agency obligations | 13,769 | 12,984 | 3,731 | (42) | 304 | (5) |
| Mutual funds | 27,155 | 21,326 | 706 | (16) | — | — |
| Equities | 4,633 | 4,052 | — | — | — | — |
| | $ 63,311 | 56,918 | 9,105 | (332) | 1,038 | (58) |

The above tables include permanently restricted assets held by others whose fair value exceeded cost by $1,209,000 at September 30, 2014 and $2,807,000 at September 30, 2013. Excluded from the tables are unrestricted assets, held at the Foundation, whose fair value exceeded cost by $496,000 at September 30, 2014 and $587,000 at September 30, 2013.

Assets whose use is limited for estimated self-insurance includes approximately $10,900,000 and $6,200,000 of other assets, substantially receivables, as of September 30, 2014 and 2013, respectively.

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2014 (in thousands):

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| Cash and cash equivalents | $ 17,838 | — | — | 17,838 |
| Domestic corporate bonds | — | 9,838 | — | 9,838 |
| U.S. government and agency obligations | — | 12,347 | — | 12,347 |
| Equity mutual funds | 14,925 | — | — | 14,925 |
| Equity funds | 331 | — | — | 331 |
| Total | 33,094 | 22,185 | — | 55,279 |
| Assets held in trust by others: | | | | |
| Perpetual trust | — | — | 15,696 | 15,696 |
| Total | $ 33,094 | 22,185 | 15,696 | 70,975 |

The following table sets forth by level, within the fair value hierarchy, the Hospital's financial instruments at fair value as of September 30, 2013 (in thousands):

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| Cash and cash equivalents | $ 2,307 | | — | 2,307 |
| Domestic corporate bonds | — | 12,723 | — | 12,723 |
| U.S. government and agency obligations | — | 11,518 | — | 11,518 |
| Equity mutual funds | 17,017 | — | — | 17,017 |
| Equity funds | 4,488 | — | — | 4,488 |
| Total | 23,812 | 24,241 | — | 48,053 |
| Assets held in trust by others: | | | | |
| Perpetual trust | — | — | 15,258 | 15,258 |
| Total | $ 23,812 | 24,241 | 15,258 | 63,311 |

Mutual funds and equities are traded actively on exchanges and price quotes for these shares are readily available.

For domestic and foreign bonds and U.S. government obligations multiple prices and price types are obtained from pricing vendors whenever possible, which enables cross-provider validations. A primary price source is identified based on asset type, class or issue for each security. The fair values of fixed-income securities are based on evaluated prices that reflect observable market information, such as actual trade information of similar securities, adjusted for observable differences.

The redemption period for the Hospital's financial instruments ranges from daily to monthly and require notification of one to five days, except for assets held in perpetual trust by others.

The following table presents additional information about investments measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended September 30 (in thousands):

| | 2014 | 2013 |
|---|---|---|
| Perpetual trust: | | |
| Fair value at beginning of the year | $ 15,258 | 14,299 |
| Net realized and change in unrealized gains | 1,177 | 1,653 |
| Appropriation of endowment assets for expenditure | (739) | (694) |
| Fair value at end of the year | $ 15,696 | 15,258 |

Assets held in trust by others represents a donor established perpetual trust held and administered by an outside trustee. The Hospital receives a specific portion of the return on the underlying assets of the perpetual trust. The investment income is recorded as unrestricted investment income in nonoperating gains (losses).

(Continued)

## (7) Property and Equipment

A summary of property and equipment at September 30, 2014 and 2013 is as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Land and land improvements (5–25 yrs) | $ | 7,911 | 7,328 |
| Buildings and building improvements (10–40 yrs) | | 67,094 | 67,017 |
| Equipment (3–25 yrs) | | 122,662 | 114,099 |
| Projects in process | | 395 | 1,217 |
| | | 198,062 | 189,661 |
| Less accumulated depreciation and amortization | | (135,691) | (125,787) |
| Property and equipment, net | $ | 62,371 | 63,874 |

Property under capital leases had a net book value of $955,000 and $1,476,000 at September 30, 2014 and 2013, respectively.

## (8) Long-Term Obligations

In May 1997 the Hospital issued $36,150,000 of State of Connecticut Health and Educational Facilities Authority (CHEFA) Bonds, Series E, dated May 1, 1997, 5.00% – 6.00% Serial and Term Bonds (Bonds) payable annually in amounts ranging from $985,000 to $3,000,000 through July 1, 2022.

The Hospital is required to maintain a Debt Service Reserve fund of the lesser of 10% of the principal amount of the Bonds, the amount required to fund the current portion of the principal and interest payable in any year, or 125% of the average annual debt service on the Bonds. The Hospital is also required to comply with certain financial covenants for the Bonds, including a Debt Service Coverage Ratio requirement of at least 1.25, a Debt Ratio requirement of no greater than 0.75 and a Current Ratio requirement of at least 1.40. The Bond agreements indicate that if the Current Ratio is below 1.40 but above 1.0 and the Debt Service Coverage Ratio is below 1.25 but above 1.0, a consultant is required.

Other long-term obligations consist of capital equipment financing notes and capital leases: Wells Fargo Equipment Finance, with interest of 5.75%, beginning August 2010 and maturing July 2015.



(Continued)

Long-term obligations at September 30, 2014 and 2013 are as follows (in thousands):

| | 2014 | 2013 |
|---|---|---|
| CHEFA Series E Bonds, principal payable annually and interest payable in semi-annual installments | $ 19,625 | 21,475 |
| Capital leases | 891 | 1,531 |
| | 20,516 | 23,006 |
| Less unamortized portion of bond discount | (116) | (142) |
| Less current portion | (2,509) | (2,490) |
| | $ 17,891 | 20,374 |

Principal payments on the Hospital's long-term obligations and capital lease payments are as follows (in thousands):

| | Long-term obligations | Capital leases |
|---|---|---|
| Year ending September 30: | | |
| 2015 | $ 1,960 | 549 |
| 2016 | 2,090 | 248 |
| 2017 | 2,215 | 94 |
| 2018 | 2,360 | — |
| 2019 | 2,510 | — |
| Thereafter | 8,490 | — |
| | $ 19,625 | 891 |
| Interest payments | | 153 |
| | | $ 1,044 |

The CHEFA Series E bonds and capital equipment financing notes are collateralized by substantially all of the Hospital's land, buildings and equipment.

Long-term debt is carried at cost. Fair values are estimated based on quoted market prices for the same or similar issues. The estimated fair value of the CHEFA Series E bonds approximates $19,635,000 as of September 30, 2014 and is classified as Level 2 for fair value disclosure purposes.

## (9) Line of Credit

The Hospital maintains a financing agreement with Webster Bank for a $5,000,000 line of credit which has an August 13, 2015 maturity date. Interest on the line of credit is at the Hospital's choice of either the lending institution's prime rate or at the LIBOR rate plus 110 basis points. At September 30, 2014 and 2013, there was no outstanding balance under this line of credit agreement. Additionally, $450,000 of the unused line of credit secures a stand-by letter of credit.



(Continued)

## (10) Unrestricted, Temporarily, and Permanently Restricted Net Assets

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2014 were as follows (in thousands):

| | | Total | Controlling interest | Noncontrolling interest |
|---|---|---|---|---|
| Unrestricted net assets, beginning of year | $ | 32,634 | 32,332 | 302 |
| Excess (deficiency) of revenues over expenses | | 12,846 | 12,414 | 432 |
| Net assets released from restriction for capital expenditures | | (48) | (48) | — |
| Transfers to affiliates | | (363) | 1 | (364) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | | (527) | (527) | — |
| Change in accumulated pension charges to unrestricted net assets | | (13,377) | (13,377) | — |
| Unrestricted net assets, end of year | $ | 31,165 | 30,795 | 370 |

The changes in consolidated unrestricted net assets attributable to the Hospital and noncontrolling interest for the year ended September 30, 2013 were as follows (in thousands):

| | | Total | Controlling interest | Noncontrolling interest |
|---|---|---|---|---|
| Unrestricted net assets, beginning of year | $ | 880 | 528 | 352 |
| Excess (deficiency) of revenues over expenses | | 10,508 | 10,153 | 355 |
| Net assets released from restriction for capital expenditures | | 545 | 545 | — |
| Transfers to affiliates | | (519) | (114) | (405) |
| Change in unrealized gains on marketable securities and other assets whose use is limited | | 401 | 401 | — |
| Change in accumulated pension charges to unrestricted net assets | | 20,819 | 20,819 | — |
| Unrestricted net assets, end of year | $ | 32,634 | 32,332 | 302 |



(Continued)

Temporarily restricted net assets are available for the following purposes at September 30, 2014 and 2013 (in thousands):

| | 2014 | 2013 |
|---|---|---|
| Cancer | $ 212 | 196 |
| Building and equipment | 421 | 428 |
| Community services | 511 | 518 |
| Education | 186 | 153 |
| Other | 1,085 | 974 |
| | $ 2,415 | 2,269 |

Permanently restricted net assets at September 30, 2014 and 2013 are restricted to (in thousands):

| | 2014 | 2013 |
|---|---|---|
| Investments held by trustee in perpetuity, the income from which is expendable to support Hospital operations | $ 15,713 | 15,287 |
| Investments held by Hospital Foundation in perpetuity, the income from which is expendable to support: | | |
| Hospital operations | 818 | 818 |
| Medical education | 150 | 150 |
| | $ 16,681 | 16,255 |

## (11) Endowment

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) adopted by the State of Connecticut (Act) provides standards to guide investing in a prudent manner and eliminated the restriction that endowment funds could not be spent below historical dollar value.

The Hospital's endowment consists of funds established for a variety of purposes including donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. At September 30, 2014 and 2013, the Hospital has no funds designated by the Board of Directors as endowment.

The Hospital has interpreted 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. 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 (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment 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 of prudence prescribed by the Act.



(Continued)

The Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds; the duration and preservation of the fund, the purposes of the Hospital and the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the Hospital, and the investment policies of the Hospital.

Endowment funds consist of the following at September 30, 2014 and 2013 (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Donor-restricted endowment funds at September 30, 2014 | $ | 457 | 16,681 | 17,138 |
| Donor-restricted endowment funds at September 30, 2013 | $ | 375 | 16,255 | 16,630 |

Changes in endowment funds for the year ended September 30, 2014 are as follows (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Endowment net assets, September 30, 2013 | $ | 375 | 16,255 | 16,630 |
| Investment return: | | | | |
| Investment income | | 110 | 913 | 1,023 |
| Net (depreciation) appreciation | | (23) | 264 | 241 |
| Total investment return | | 87 | 1,177 | 1,264 |
| Appropriation of endowment assets for expenditure | | (5) | (751) | (756) |
| Endowment net assets, September 30, 2014 | $ | 457 | 16,681 | 17,138 |

Changes in endowment funds for the year ended September 30, 2013 are as follows (in thousands):

| | | Temporarily restricted | Permanently restricted | Total |
|---|---|---|---|---|
| Endowment net assets, September 30, 2012 | $ | 261 | 15,306 | 15,567 |
| Investment return: | | | | |
| Investment income | | 96 | 789 | 885 |
| Net appreciation | | 19 | 864 | 883 |
| Total investment return | | 115 | 1,653 | 1,768 |
| Appropriation of endowment assets for expenditure | | (1) | (704) | (705) |
| Endowment net assets, September 30, 2013 | $ | 375 | 16,255 | 16,630 |

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specified period. Funds held in trust by others represents a donor established perpetual trust held and administered by an outside trustee and are not within the Hospital's control as to spending and investment policies.

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 emphasis on investments in equities and fixed income investments to achieve its long-term return objectives with prudent risk constraints.

The Hospital follows a policy of spending an amount that approximates the investment income earned, in addition to specific purchases of capital equipment. Accordingly, the Hospital expects its spending policy will allow its endowment funds to be maintained in perpetuity by growing at a rate at least equal to the planned payouts. Additional real endowment growth will be provided through new gifts and any excess investment return.

## (12) Professional and General Liability

Prior to July 1, 2009, the Hospital purchased limits of professional and general liability from Partners Interinsurance Exchange (PIE) to cover risks up to specified limits. Within PIE the Hospital maintained retentions net to its own account by type of coverage. A claims made reinsurance contract was purchased each fiscal year that provided coverage above these retentions. Beginning January 1, 2002, the professional liability coverage provided for total limits, with respect to professional liability, of $18 million per claim and $27 million in the aggregate, with a retention inside that limit of $3,000,000 per incident applying as net to the Hospital's account within PIE. The general liability coverage provided limits of $16 million per claim and $19 million in the aggregate with a retention of $1,000,000 per incident and $4,000,000 in the annual aggregate retained as net to the Hospital's account within PIE. The Hospital paid an actuarially

determined premium to PIE for the purpose of setting aside assets to cover the reasonable value of ultimate expected loss retained as net within PIE.

During June 2009, the Hospital established the Indemnity Company as a successor to the Hospital's financial interest in PIE. On July 1, 2009 the Hospital's account in PIE was transferred to the Indemnity Company. The Hospital and certain affiliates continue to purchase limits of professional and general liability from the Indemnity Company at levels previously purchased from PIE.

Professional liability have been asserted against the Hospital by various claimants. The claims are in various stages of assessment and resolution. There are also known and unknown incidents that have occurred through September 30, 2014 that may result in the assertion of additional claims. Actuarially determined premiums are paid in order to set aside assets to cover the reasonable value of ultimate expected losses. The resolution of these claims, including those unasserted, involves extended evaluation of the facts, including the involvement of independent specialists. As a result, the estimates made are reassessed periodically and are subject to change. Hospital management, along with its consulting actuaries, accrued its best estimate of professional and general liabilities. Hospital management believes that the ultimate settlement of these claims will not have a material impact on the Hospital's consolidated financial position or results of their operations, as adequate self-insurance reserves, Indemnity Company assets and reinsurance are in place.

The Indemnity Company entered into a loss portfolio transfer (LPT) on July 1, 2009 with PIE. The losses associated with this transaction did not transfer insurance risk to the Indemnity Company. As such, this LPT is accounted for using deposit accounting, which requires offsetting assets and liabilities.

Activity in the reserves for premiums held on deposit included in self-insurance liability is summarized as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Reserves for premiums held on deposit at beginning of year | $ | 10,544 | 6,657 |
| Current period payments from loss escrow | | 4,600 | 2,450 |
| Change in reserve for premiums held on deposit for loss portfolio transfer | | 374 | 6,673 |
| Current period payments from reserves for premiums held on deposit | | 403 | 5,236 |
| Reserves for premiums held on deposit at end of year | $ | 15,115 | 10,544 |

Activity in the self-insurance liability for unpaid losses and loss adjustment expenses for prospective losses is summarized as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Balance at beginning of period | $ | 14,993 | 14,750 |
| Less reinsurance recoverable | | (2,650) | (2,300) |
| Net balance at beginning of period | | 12,343 | 12,450 |
| Incurred related to: | | | |
| Current year | | 4,547 | 4,493 |
| Prior years | | (993) | (4,034) |
| Total incurred | | 3,554 | 459 |
| Paid related to: | | | |
| Current year | | 73 | 3 |
| Prior years | | 350 | 563 |
| Total paid | | 423 | 566 |
| Net balance at end of period | | 15,474 | 12,343 |
| Add reinsurance recoverable | | 2,750 | 2,650 |
| Balance at end of period | $ | 18,224 | 14,993 |

The provision for incurred losses related to prior years (relating to loss incurred subsequent to the loss portfolio transfer from Partner Interinsurance Exchange at July 1, 2009) totaled ($993,000) and ($4,034,000) for 2014 and 2013, respectively, the result of development on outstanding claims.

## (13) Retirement Plans

### *(a) Defined Benefit Plan*

The Hospital has a noncontributory, defined benefit pension plan (the Plan) for most employees, which is funded with available cash flow. The Plan is qualified as a "Church Plan" and is therefore exempt from a majority of ERISA regulations. Plan benefits are not guaranteed by the Pension Benefit Guaranty Corporation. The Plan was frozen to new entrants in 1997. In 2004, the Plan's benefits were curtailed to eliminate participants' earnings of additional benefits for future services.

The following table sets forth the Plan's funded status at September 30, 2014 and 2013, the Plan measurement date, (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Change in benefit obligation: | | | |
| Benefit obligation, beginning of year | $ | 124,196 | 138,482 |
| Interest cost | | 6,064 | 5,613 |
| Actuarial loss (gain) | | 17,454 | (13,726) |
| Benefits paid | | (6,786) | (6,173) |
| Benefit obligation, end of year | | 140,928 | 124,196 |
| Change in plan assets: | | | |
| Fair value of plan assets, beginning of year | | 66,215 | 59,683 |
| Actual return on plan assets | | 6,091 | 7,340 |
| Contributions | | 4,121 | 5,365 |
| Benefits paid | | (6,786) | (6,173) |
| Fair value of plan assets, end of year | | 69,641 | 66,215 |
| Funded status at year end | $ | (71,287) | (57,981) |
| Amounts recognized in consolidated balance sheets consist of: | | | |
| Noncurrent liabilities | $ | (71,287) | (57,981) |
| Accumulated charges to unrestricted net assets, consisting of net actuarial losses | | 56,338 | 42,961 |
| Net amount recognized | $ | (14,949) | (15,020) |

The prior service cost that will be amortized from accumulated charges to unrestricted net assets into net periodic benefit cost over the next fiscal year is $4,427,000.

The accumulated benefit obligation for the pension plan was $140,928,000 and $124,196,000 at September 30, 2014 and 2013, respectively. Net periodic benefit cost recognized in 2014 and 2013 was (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Components of net periodic benefit cost: | | | |
| Interest cost | $ | 6,064 | 5,613 |
| Expected return on plan assets | | (5,064) | (4,724) |
| Net amortization and deferral | | 3,050 | 4,477 |
| Net periodic benefit cost | | 4,050 | 5,366 |
| Other changes in plan assets and benefit obligation recognized as (charges) credits to unrestricted net assets in 2014 and 2013 are as follows (in thousands): | | | |
| Net (loss) gain | | (10,327) | 25,296 |
| Net amortization and deferral | | (3,050) | (4,477) |
| (Decrease) increase recognized in changes to unrestricted net assets | | (13,377) | 20,819 |
| (Decrease) increase to unrestricted net assets associated with recognized net periodic benefit cost and (charge) credit to accumulated pension charge | $ | (17,427) | 15,453 |

Weighted average assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years end September 30, 2014 and 2013 were as follows:

| | 2014 | 2013 |
|---|---|---|
| Weighted average assumptions at September 30: | | |
| Discount rate for benefit obligations | 4.55% | 5.02% |
| Discount rate for net periodic benefit cost | 5.02 | 4.15 |
| Expected return on plan assets | 8.00 | 8.00 |

The discount rate is based on high-grade bond yield curve under which benefits were projected and discounted at spot rates along the curve. The discount rate was then determined as a single rate yielding the same present values.

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2014 (in thousands):

| | | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|---|
| Money market funds | $ | 2,241 | — | — | 2,241 |
| Domestic corporate bonds | | — | 12,827 | — | 12,827 |
| U.S. government and agency obligations | | — | 261 | — | 261 |
| Equity mutual funds | | 47,991 | — | — | 47,991 |
| Fixed income mutual funds | | 6,321 | — | — | 6,321 |
| Preferred equity securities | | — | — | — | — |
| Total | $ | 56,553 | 13,088 | — | 69,641 |

The following table sets forth by level, within the fair value hierarchy, the pension plan's financial instruments at fair value as of September 30, 2013 (in thousands):

| | | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|---|
| Money market funds | $ | 1,745 | — | — | 1,745 |
| Domestic corporate bonds | | — | 14,443 | — | 14,443 |
| U.S. government and agency obligations | | — | 291 | — | 291 |
| Equity mutual funds | | 44,545 | — | — | 44,545 |
| Fixed income mutual funds | | 4,747 | — | — | 4,747 |
| Preferred equity securities | | — | 444 | — | 444 |
| Total | $ | 51,037 | 15,178 | — | 66,215 |

The redemption period for the Plan's financial instruments ranges from daily to monthly and require notification of one to five days.

The expected long-term rate of return for the plan's total assets is based on the expected return of each of the above categories, weighted based on the target allocation of each class. Equity securities are expected to return 9% to 10% over the long-term, while debt securities are expected to return between 4% and 7%. Money market funds are held to pursue market opportunities.

The investment policy, as established by the Investment Committee, is to earn a total return in any five-year period that will have exceeded the interest assumption in the actuarial plan valuation for that five-year period. For performance evaluation purposes, all rates of return will be examined on a net-of-fee basis. The pension assets are to be broadly diversified so as to limit the impact of large losses in individual investments on the total portfolio. The asset allocation is reviewed on a quarterly basis.

In the aggregate, contributions to the pension plan are expected to be $5,400,000 in 2015.

The following benefit payments are expected to be paid (in thousands):

| | | |
|---|---|---|
| 2015 | $ | 7,408 |
| 2016 | | 7,574 |
| 2017 | | 7,848 |
| 2018 | | 8,196 |
| 2019 | | 8,422 |
| 2020 through 2024 | | 45,151 |
| | $ | 84,599 |

*(b)* ***Defined Contribution Plan***

The Hospital established a defined contribution plan when it reduced the benefits of the Plan via amendment in 1997. The defined contribution plan provides for a Hospital match up to a certain percentage of employee contributions. Expenses related to the defined contribution plan amounted to $3,885,000 and $5,005,000 in 2014 and 2013, respectively, and are included in employee benefits in the accompanying consolidated statements of operations.

*(c)* ***Supplemental Pension Plan***

In addition, the Hospital has an unfunded supplemental pension plan for a small group of long term employees, who are now retired. The Hospital's recorded liability was $975,000 and $923,000 at September 30, 2014 and 2013, respectively.

**(14) Leases and Rental Expenses**

Rental expense aggregated approximately $6,303,000 and $6,138,000 for the years ended September 30, 2014 and 2013, respectively. Minimum future rental commitments on all noncancelable operating leases with initial or remaining terms of more than one year are as follows (in thousands):

| | | |
|---|---|---|
| Fiscal year: | | |
| 2015 | $ | 3,208 |
| 2016 | | 2,429 |
| 2017 | | 1,654 |
| 2018 | | 1,349 |
| 2019 | | 1,186 |
| 2020 and thereafter | | 5,253 |
| | $ | 15,079 |

The Hospital rents space from SMHS in a medical office building for approximately $13,000 per month.

## (15) Cancer Center

During 1997, the Hospital entered into an agreement with Waterbury Hospital to develop a joint Cancer Care Center, known as the Harold Leever Regional Cancer Center (HLRCC) that provides treatment services to cancer patients in the greater Waterbury area. The Hospital is entitled to distributions at the discretion of HLRCC's Board of Directors, which is selected by Waterbury Hospital and the Hospital on a 50/50 basis. The Hospital's investment in HLRCC is carried using the equity method, and the carrying value is approximately $9,562,000 and $10,151,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($424,000) and $414,000 in 2014 and 2013, respectively.

## (16) Heart Center of Greater Waterbury

The Hospital and Waterbury Hospital operate an advanced cardiac care program known as the Heart Center of Greater Waterbury, Inc. (HCGW). Patients at the Hospital and Waterbury Hospital are provided access to services such as angioplasty and open heart surgery. Procedures are performed at both hospitals, each recording related revenues and expenses. The HCGW, a MSO that provides administrative support and management functions to the program, has a Board of Directors selected by Waterbury Hospital and the Hospital on a 50/50 basis. HCGW incurs costs, which are funded by the hospitals, to market the program and derives no net assets from its activities. The Hospital expensed $118,000 and $131,000 of funding, in 2014 and 2013, respectively.

## (17) Investments in Joint Venture Arrangements

### *Naugatuck Valley MRI Limited Partnership*

The Hospital is a 1% general partner and a 47% limited partner in the Naugatuck Valley MRI Limited Partnership, which provides diagnostic imaging services in Waterbury. The investment is carried on the equity basis, and the carrying value is approximately $199,000 and $255,000 at September 30, 2014 and 2013, respectively. Equity in earnings was approximately ($55,000) and $402,000 in 2014 and 2013, respectively.

## (18) Other Operating Revenues

Components of other operating revenues for the years ended September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Investment income related to short-term investments and investments for self-insurance | $ | 280 | 276 |
| Cafeteria | | 1,170 | 1,173 |
| Outside services | | 545 | 274 |
| State grants | | 656 | 742 |
| Parking fees | | 232 | 320 |
| Day care | | 718 | 665 |
| Rentals | | 1,242 | 1,263 |
| Meaningful use | | 2,962 | 1,149 |
| Other | | 1,971 | 1,009 |
| Total | $ | 9,776 | 6,871 |

## (19) Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 are as follows (in thousands):

| | | 2014 | 2013 |
|---|---|---|---|
| Health care services | $ | 225,237 | 215,207 |
| General and administrative | | 43,745 | 39,372 |
| | $ | 268,982 | 254,579 |

## (20) Activities Between Affiliates

During 2014 and 2013, the Foundation distributed $80,000 and $311,000, respectively, to the Hospital to support programs and services.

In addition to the lease activity with affiliates described in note 14, all employees of SMHS and the Foundation are paid through the Hospital's payroll system, and the amounts paid are charged directly to the related affiliate. In addition, time spent by certain Hospital employees on affiliate activities is charged to the related affiliate.

## (21) Subsequent Events

The Hospital has evaluated events through December 22, 2014, which represents the date the consolidated financial statements were available to be issued and noted no subsequent events that would have impacted the Hospital's consolidated financial statements except as disclosed below.

Exhibit 1

**SAINT MARY'S HOSPITAL, INC.**

Consolidating Balance Sheet

September 30, 2014

(In thousands)

| | Saint Mary's Hospital | Franklin Medical Group, P.C. | Saint Mary's Indemnity Company, LLC | Southbury Diagnostic Imaging Center, Inc. | Eliminations | 2014 Consolidated |
|---|---|---|---|---|---|---|
| Current assets: | | | | | | |
| Cash and cash equivalents | $ 24,610 | 823 | — | 364 | — | 25,797 |
| Short-term investments | 17 | — | — | — | — | 17 |
| Current portion of assets whose use is limited | 1,145 | — | 4,803 | — | — | 5,948 |
| Accounts receivable, net | 26,816 | 2,999 | (68) | 381 | 68 | 30,196 |
| Other current assets | 6,108 | 253 | 5,749 | 17 | (5,515) | 6,612 |
| Total current assets | 58,696 | 4,075 | 10,484 | 762 | (5,447) | 68,570 |
| Marketable securities | 20,803 | — | — | — | — | 20,803 |
| Assets whose use is limited: | | | | | | |
| By donor and held in trust by others | 15,696 | — | — | — | — | 15,696 |
| For estimated self-insurance liability | — | — | 41,038 | — | — | 41,038 |
| By bond indenture | 4,321 | — | — | — | — | 4,321 |
| Net interest in Foundation | 5,182 | — | — | — | — | 5,182 |
| Other | 6 | — | — | — | — | 6 |
| Total assets whose use is limited | 25,205 | — | 41,038 | — | — | 66,243 |
| Less current portion of assets whose use is limited | 1,145 | — | 4,803 | — | — | 5,948 |
| Noncurrent assets whose use is limited | 24,060 | — | 36,235 | — | — | 60,295 |
| Property and equipment, net | 59,768 | 1,417 | — | 1,186 | — | 62,371 |
| Other assets: | | | | | | |
| Investments in joint venture arrangements | 23,723 | — | — | — | (13,699) | 10,024 |
| Deferred financing costs, net | 103 | — | — | — | — | 103 |
| Total other assets | 23,826 | — | — | — | (13,699) | 10,127 |
| Total assets | $ 187,153 | 5,492 | 46,719 | 1,948 | (19,146) | 222,166 |



(Continued)

Exhibit 1

**SAINT MARY'S HOSPITAL, INC.**

Consolidating Balance Sheet

September 30, 2014

(In thousands)

| | Saint Mary's Hospital | Franklin Medical Group, P.C. | Saint Mary's Indemnity Company, LLC | Southbury Diagnostic Imaging Center, Inc. | Eliminations | 2014 Consolidated |
|---|---|---|---|---|---|---|
| Current liabilities: | | | | | | |
| Current portion of long-term obligations | $ 2,101 | — | — | 408 | — | 2,509 |
| Accounts payable | 16,795 | 432 | — | 25 | — | 17,252 |
| Salaries, wages, and payroll withholdings | 3,974 | 1,370 | — | 299 | — | 5,643 |
| Due to third-party payors, net | 783 | — | — | — | — | 783 |
| Accrued expenses and other current liabilities | 13,994 | 504 | 5,038 | 219 | (5,447) | 14,308 |
| Total current liabilities | 37,647 | 2,306 | 5,038 | 951 | (5,447) | 40,495 |
| Long-term liabilities: | | | | | | |
| Long-term obligations, net of current portion | 17,818 | — | — | 73 | — | 17,891 |
| Estimated self-insurance liability | 3,278 | — | 28,536 | — | — | 31,814 |
| Pension and deferred compensation | 72,182 | — | — | — | — | 72,182 |
| Other long-term liabilities | 9,464 | 59 | — | — | — | 9,523 |
| Total long-term liabilities | 102,742 | 59 | 28,536 | 73 | — | 131,410 |
| Net assets (deficit): | | | | | | |
| Unrestricted | 27,668 | 3,127 | 13,145 | 924 | (14,069) | 30,795 |
| Noncontrolling interest in subsidiaries | — | — | — | — | 370 | 370 |
| Total unrestricted | 27,668 | 3,127 | 13,145 | 924 | (13,699) | 31,165 |
| Temporarily restricted | 2,415 | — | — | — | — | 2,415 |
| Permanently restricted | 16,681 | — | — | — | — | 16,681 |
| Total net assets | 46,764 | 3,127 | 13,145 | 924 | (13,699) | 50,261 |
| Total liabilities and net assets | $ 187,153 | 5,492 | 46,719 | 1,948 | (19,146) | 222,166 |

See accompanying independent auditors' report.

Exhibit 2

**SAINT MARY'S HOSPITAL, INC.**

Consolidating Statement of Operations

Year ended September 30, 2014

(In thousands)

| | Saint Mary's Hospital | Franklin Medical Group, P.C. | Saint Mary's Indemnity Company, LLC | Southbury Diagnostic Diagnostic Imaging Center, Inc. | Eliminations | 2014 Consolidated |
|---|---|---|---|---|---|---|
| Revenues: | | | | | | |
| Revenue from patient services, net of contractual allowances | $ 248,807 | 24,157 | — | 6,197 | — | 279,161 |
| Provision for uncollectible accounts | (10,078) | (996) | — | — | — | (11,074) |
| Net revenue from patient services | 238,729 | 23,161 | — | 6,197 | — | 268,087 |
| Other operating revenues | 8,706 | 4,039 | 5,070 | 16 | (8,055) | 9,776 |
| Total revenues | 247,435 | 27,200 | 5,070 | 6,213 | (8,055) | 277,863 |
| Expenses: | | | | | | |
| Salaries and wages | 85,350 | 26,689 | — | 1,168 | — | 113,207 |
| Employee benefits | 24,562 | 3,778 | — | 280 | — | 28,620 |
| Supplies and other expenses | 106,022 | 9,260 | 4,092 | 3,370 | (7,482) | 115,262 |
| Depreciation and amortization | 9,888 | 283 | — | 284 | — | 10,455 |
| Interest | 1,405 | — | — | 33 | — | 1,438 |
| Total expenses | 227,227 | 40,010 | 4,092 | 5,135 | (7,482) | 268,982 |
| Operating income (loss) | 20,208 | (12,810) | 978 | 1,078 | (573) | 8,881 |
| Nonoperating gains (losses): | | | | | | |
| Investment income, net | 2,279 | — | 1,545 | — | — | 3,824 |
| Equity in earnings of joint ventures | 3,359 | — | — | — | (3,170) | 189 |
| Change in net assets of Foundation | 281 | — | — | — | — | 281 |
| Net loss on disposal of assets | (46) | — | — | — | — | (46) |
| Other | (856) | — | — | — | 573 | (283) |
| Total nonoperating gains (losses), net | 5,017 | — | 1,545 | — | (2,597) | 3,965 |
| Excess (deficiency) of revenues over expenses | 25,225 | (12,810) | 2,523 | 1,078 | (3,170) | 12,846 |
| Net assets released from restriction | (48) | — | — | — | — | (48) |
| Capital transactions, net | (14,778) | 14,778 | — | (910) | 547 | (363) |
| Change in unrealized (losses) gains on marketable securities and other assets whose use is limited | (527) | — | (486) | — | 486 | (527) |
| Change in accumulated pension charges to unrestricted net assets | (13,377) | — | — | — | — | (13,377) |
| (Decrease) increase in unrestricted net assets | $ (3,505) | 1,968 | 2,037 | 168 | (2,137) | (1,469) |

See accompanying independent auditors' report.

Saint Mary's HOSPITAL

# DAILY CENSUS & REVENUE REPORT

August 21, 2015

| UNIT | DEPT | STAFFED BEDS | DAILY BUDGET Patient Days | DAILY ACTUAL Patient Days | DAILY ACTUAL Discharges | MTD BUDGET Patient Days | MTD ACTUAL Patient Days | MTD VAR Patient Days | MTD BUDGET Discharges | MTD ACTUAL Discharges | MTD VAR Discharges | MTD BUDGET Length of Stay | MTD ACTUAL Length of Stay | MTD VAR Length of Stay |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical Acute SH5 | 3130 | 21 | 19 | 16 | 10 | 404 | 365 | -10% | 96 | 108 | 12% | 4.20 | 3.38 | 20% |
| Behave Hlth Srvc OB1 | 3570 | 12 | 11 | 12 | 2 | 233 | 243 | 4% | 45 | 43 | -4% | 5.21 | 5.65 | -8% |
| Telemetry | 3140 | 20 | 18 | 19 | 4 | 375 | 311 | -17% | 81 | 74 | -8% | 4.65 | 4.20 | 10% |
| OB-4 Ortho/Neuro | 3150 | 30 | 22 | 25 | 5 | 457 | 324 | -29% | 113 | 88 | -22% | 4.04 | 3.68 | 9% |
| X-3 Medical Oncology | 3320 | 26 | 23 | - | - | 489 | 329 | -33% | 96 | 89 | -7% | 5.08 | 3.70 | 27% |
| OB-7 General Surgery | 3200 | 23 | 18 | 16 | 8 | 381 | 264 | -31% | 129 | 84 | -35% | 2.96 | 3.14 | -6% |
| Critical Care Unit | 3500 | 16 | 11 | 9 | 1 | 231 | 200 | -13% | 20 | 15 | -24% | 11.76 | 13.33 | -13% |
| Cardiovascular Unit | 3510 | 8 | 4 | 4 | - | 75 | 74 | -2% | 26 | 9 | -65% | 2.92 | 8.22 | -182% |
| Labor/Delivery | 4070 | 23 | 8 | 12 | 2 | 175 | 183 | 5% | 64 | 71 | 10% | 2.72 | 2.58 | 5% |
| Holding | | - | 4 | 9 | 1 | 92 | 76 | -18% | 8 | 3 | -63% | 11.33 | 25.33 | -124% |
| OB/Gyn | 3600 | - | 0 | - | - | 6 | 3 | -51% | - | 2 | #DIV/0! | | 1.50 | #VALUE! |
| **SubTotal** | | **179** | **139** | **122** | **33** | **2,919** | **2,372** | **-19%** | **677** | **586** | **-13%** | **4.31** | **4.05** | **6%** |
| | | | | | | | | | | | | | | |
| Neonatal ICU (Critical Care Nurs) | 3750 | 9 | 4 | 3 | - | 76 | 74 | -2% | 8 | 9 | 11% | 9.33 | 8.22 | 12% |
| Nursery | 3700 | 23 | 6 | 11 | 2 | 134 | 148 | 10% | 47 | 62 | 33% | 2.87 | 2.39 | 17% |
| Birthing Center | 4310 | 2 | 0 | - | - | 1 | - | -100% | 1 | - | -100% | 2.00 | | #VALUE! |
| **SubTotal** | | **34** | **10** | **14** | **2** | **211** | **222** | **5%** | **56** | **71** | **28%** | **3.80** | **3.13** | **18%** |
| | | | | | | | | | | | | | | |
| **TOTAL (excl Psych and Nursery)** | | **178** | **132** | **113** | **31** | **2,763** | **2,203** | **-20%** | **642** | **552** | **-14%** | **4.31** | **3.99** | **7%** |
| | | | | | | | | | | | | | | |
| **GRAND TOTAL (incl Psych & Nursery)** | | **213** | **149** | **136** | **35** | **3,130** | **2,594** | **-17%** | **733** | **657** | **-10%** | **4.27** | **3.95** | **8%** |

| | | | | |
|---|---|---|---|---|
| Adult & Peds Occupancy | 78% | 68% | 78% | 63% |
| NICU Occupancy | 40% | 33% | 40% | 39% |
| Nursery Occupancy | 28% | 48% | 28% | 31% |
| Total Occupancy | 70% | 64% | 70% | 58% |

| | DAILY BUDGET | DAILY ACTUAL | MTD BUDGET | MTD ACTUAL | MTD VAR |
|---|---|---|---|---|---|
| Observation | 6 | 6 | 134 | 173 | 29% |
| OP Surgery | 61 | 54 | 923 | 854 | -7% |
| Outpatient/Ref Lab | 481 | 452 | 7,628 | 7,539 | -1% |
| Psych OP | 5 | 1 | 75 | 41 | -45% |
| Series/Recurring | 22 | 19 | 342 | 747 | 118% |
| Urgent Care | 73 | 59 | 1,396 | 1,206 | -14% |
| **O/P Visits (excl ER Visits)** | **648** | **591** | **10,498** | **10,580** | **1%** |
| ER Visits (only includes discharges) | 178 | 173 | 3,735 | 3,678 | -2% |
| **Total O/P Visits (incl ER Visits)** | **826** | **764** | **14,233** | **14,258** | **0%** |

Note: E. Main Urgent Care Center is budgeted, but is not opened yet.

| CHARGE TOTALS: | Daily Budget | Daily Actual | Daily Proj Excess / Shortfall | MTD Budget | MTD Actual | MTD Proj Excess / Shortfall | YTD Budget | 271400155.2 | YTD Proj Excess / Shortfall |
|---|---|---|---|---|---|---|---|---|---|
| IP Actual | 845,681 | 849,771 | $4,090 | 17,759,299 | 15,514,430 | ($2,244,869) | 268,562,483 | 275,230,061 | $6,667,578 |
| OP Actual | 1,581,240 | 1,265,268 | ($315,972) | 25,567,827 | 24,489,757 | ($1,078,070) | 378,303,382 | 380,918,026 | $2,614,644 |
| **Total** | **$2,426,921** | **$2,115,039** | **($311,882)** | **$43,327,126** | **$40,004,186** | **($3,322,940)** | **$646,865,865** | **$656,148,086** | **$9,282,221** |
| **Budget variance** | **-12.9%** | | | **-7.7%** | | | **1.4%** | | |

| | 7/31/2015 | 8/21/2015 | Change |
|---|---|---|---|
| IP Accounts Receivable | 23,037,971 | 20,577,457 | (2,460,514) |
| OP Accounts Receivable | 28,730,929 | 34,881,657 | 6,150,728 |
| **ACCOUNTS RECEIVABLE:** | **$51,768,900** | **$55,459,114** | **3,690,214** |
| IP Unbilled Receivable | 7,098,463 | 9,088,554 | 1,990,091 |
| OP Unbilled Receivable | 16,718,641 | 14,714,253 | (2,004,388) |
| **UNBILLED RECEIVABLE:** | **23,817,104** | **23,802,807** | **($14,297)** |
| | **$75,586,004** | **$79,261,921** | **$3,675,917** |

Saint Mary's HOSPITAL

# DAILY CENSUS & REVENUE REPORT

August 22, 2015

| UNIT | DEPT | STAFFED BEDS | DAILY BUDGET Patient Days | DAILY ACTUAL Patient Days | DAILY ACTUAL Discharges | MTD BUDGET Patient Days | MTD ACTUAL Patient Days | MTD VAR Patient Days | MTD BUDGET Discharges | MTD ACTUAL Discharges | MTD VAR Discharges | MTD BUDGET Length of Stay | MTD ACTUAL Length of Stay | MTD VAR Length of Stay |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical Acute SH5 | 3130 | 21 | 19 | 15 | 8 | 424 | 380 | -10% | 101 | 116 | 15% | 4.20 | 3.28 | 22% |
| Behave Hlth Srvc OB1 | 3570 | 12 | 11 | 12 | - | 244 | 255 | 4% | 47 | 43 | -8% | 5.21 | 5.93 | 14% |
| Telemetry | 3140 | 20 | 18 | 18 | 4 | 392 | 329 | -16% | 84 | 78 | -8% | 4.65 | 4.22 | 9% |
| OB-4 Ortho/Neuro | 3150 | 30 | 22 | 24 | 9 | 479 | 348 | -27% | 119 | 97 | -18% | 4.04 | 3.59 | 11% |
| X-3 Medical Oncology | 3320 | 26 | 23 | - | - | 512 | 329 | -36% | 101 | 89 | -12% | 5.08 | 3.70 | 27% |
| OB-7 General Surgery | 3200 | 23 | 18 | 18 | 4 | 400 | 282 | -29% | 135 | 88 | -35% | 2.96 | 3.20 | -8% |
| Critical Care Unit | 3500 | 16 | 11 | 10 | 1 | 242 | 210 | -13% | 21 | 16 | -22% | 11.76 | 13.13 | -12% |
| Cardiovascular Unit | 3510 | 8 | 4 | 4 | - | 79 | 78 | -1% | 27 | 9 | -67% | 2.92 | 8.67 | -197% |
| Labor/Delivery | 4070 | 23 | 8 | 7 | 6 | 183 | 190 | 4% | 67 | 77 | 14% | 2.72 | 2.47 | 9% |
| Holding | | - | 4 | 4 | 1 | 97 | 80 | -17% | 9 | 4 | -53% | 11.33 | 20.00 | -77% |
| OB/Gyn | 3600 | - | 0 | - | - | 6 | 3 | -53% | - | 2 | #DIV/0! | | 1.50 | #VALUE! |
| **SubTotal** | | 179 | 139 | 112 | 33 | 3,058 | 2,484 | -19% | 710 | 619 | -13% | 4.31 | 4.01 | 7% |
| | | | | | | | | | | | | | | |
| Neonatal ICU (Critical Care Nurs) | 3750 | 9 | 4 | 3 | - | 79 | 77 | -3% | 9 | 9 | 6% | 9.33 | 8.56 | 8% |
| Nursery | 3700 | 23 | 6 | 7 | 5 | 141 | 155 | 10% | 49 | 67 | 37% | 2.87 | 2.31 | 20% |
| Birthing Center | 4310 | 2 | 0 | - | - | 1 | - | -100% | 1 | - | -100% | 2.00 | | #VALUE! |
| **SubTotal** | | 34 | 10 | 10 | 5 | 221 | 232 | 5% | 58 | 76 | 31% | 3.80 | 3.05 | 20% |
| | | | | | | | | | | | | | | |
| **TOTAL (excl Psych and Nursery)** | | 178 | 132 | 103 | 33 | 2,895 | 2,306 | -20% | 672 | 585 | -13% | 4.31 | 3.94 | 9% |
| | | | | | | | | | | | | | | |
| **GRAND TOTAL (incl Psych & Nursery)** | | 213 | 149 | 122 | 38 | 3,279 | 2,716 | -17% | 768 | 695 | -9% | 4.27 | 3.91 | 8% |

| | | | | |
|---|---|---|---|---|
| Adult & Peds Occupancy | 78% | 63% | 78% | 63% |
| NICU Occupancy | 40% | 33% | 40% | 39% |
| Nursery Occupancy | 28% | 30% | 28% | 31% |
| Total Occupancy | 70% | 57% | 70% | 58% |

| | DAILY BUDGET | DAILY ACTUAL | MTD BUDGET | MTD ACTUAL | MTD VAR |
|---|---|---|---|---|---|
| Observation | 6 | 7 | 140 | 180 | 29% |
| OP Surgery | - | 2 | 923 | 856 | -7% |
| Outpatient/Ref Lab | 110 | 107 | 7,738 | 7,666 | -1% |
| Psych OP | - | - | 75 | 40 | -45% |
| Series/Recurring | - | 2 | 342 | 749 | 119% |
| Urgent Care | 50 | 61 | 1,446 | 1,267 | -12% |
| **O/P Visits (excl ER Visits)** | 166 | 179 | 10,664 | 10,759 | 1% |
| ER Visits (only includes discharges) | 178 | 164 | 3,913 | 3,842 | -2% |
| **Total O/P Visits (incl ER Visits)** | 344 | 343 | 14,577 | 14,601 | 0% |

Note: E. Main Urgent Care Center is budgeted, but is not opened yet.

| CHARGE TOTALS: | Daily Budget | Daily Actual | Daily Proj Excess / Shortfall | MTD Budget | MTD Actual | MTD Proj Excess / Shortfall | YTD Budget | 271400155.2 | YTD Proj Excess / Shortfall |
|---|---|---|---|---|---|---|---|---|---|
| IP Actual | 845,681 | 509,906 | ($335,775) | 18,604,980 | 16,024,335 | ($2,580,645) | 269,408,164 | 275,739,966 | $6,331,803 |
| OP Actual | 308,205 | 400,631 | $92,426 | 25,876,032 | 24,890,388 | ($985,644) | 378,611,587 | 381,318,657 | $2,707,070 |
| **Total** | $1,153,886 | $910,537 | ($243,349) | $44,481,012 | $40,914,723 | ($3,566,289) | $648,019,751 | $657,058,623 | $9,038,872 |
| **Budget variance** | -21.1% | | | -8.0% | | | 1.4% | | |

| | 7/31/2015 | 8/22/2015 | Change |
|---|---|---|---|
| IP Accounts Receivable | 23,037,971 | 20,577,457 | (2,460,514) |
| OP Accounts Receivable | 28,730,929 | 34,881,657 | 6,150,728 |
| **ACCOUNTS RECEIVABLE:** | $51,768,900 | $55,459,114 | 3,690,214 |
| IP Unbilled Receivable | 7,098,463 | 9,598,460 | 2,499,997 |
| OP Unbilled Receivable | 16,718,641 | 15,114,884 | (1,603,757) |
| **UNBILLED RECEIVABLE:** | 23,817,104 | 24,713,344 | $896,240 |
| | $75,586,004 | $80,172,458 | $4,586,454 |

# EXHIBIT S6

**Schedule H, Part I, Section 7 - Financial Assisstance**

| | | FY 2014 | 3% FY 2015 | 3% FY 2016 |
|---|---|---|---|---|
| a | Financial Assistance at cost | 328,346 | 338,196 | 348,342 |
| b | Medicaid | 13,083,195 | 13,475,691 | 13,879,962 |
| c | Cost of other means-tested government programs | | - | |
| d | Total Financial Assistance | 13,411,541 | 13,813,887 | 14,228,304 |
| | **Other Benefits** | | - | |
| e | Community health improvement services and community benefit operations | 147,207 | 151,623 | 156,172 |
| f | Health professions education | 2,658,321 | 2,738,071 | 2,820,213 |
| g | Subsidized health services | 1,386,130 | 1,427,714 | 1,470,545 |
| h | Research | 165,239 | 170,196 | 175,302 |
| i | Cash and in-kind contributions for community benefit | 70,911 | 73,038 | 75,229 |
| j | Total Other Benefits | 4,427,808 | 4,560,642 | 4,697,462 |
| k | Total | 17,839,349 | 18,374,529 | 18,925,765 |

**Schedule H, Part II - Community Building Activities**

| | | FY 2014 | FY 2015 | FY 2016 |
|---|---|---|---|---|
| 1 | Physical improvements and housing | 202 | 208 | 214 |
| 2 | Economic development | | | |
| 3 | Community support | | | |
| 4 | Environmental improvements | | | |
| 5 | Leadership development and training for community members | | | |
| 6 | Coalition building | | | |
| 7 | Community health improvement advocacy | | | |
| 8 | Workforce development | 169,504 | 174,589 | 179,827 |
| 9 | Other | | | |
| 10 | Total | 169,706 | 174,797 | 180,041 |

| 3% FY 2017 | 3% FY 2018 |
|---|---|
| 358,793 | 369,556 |
| 14,296,360 | 14,725,251 |
| | |
| 14,655,153 | 15,094,808 |

| | |
|---|---|
| 160,857 | 165,683 |
| 2,904,819 | 2,991,964 |
| 1,514,662 | 1,560,102 |
| 180,561 | 185,978 |
| 77,486 | 79,811 |
| 4,838,385 | 4,983,537 |
| 19,493,538 | 20,078,344 |

| FY 2017 | FY 2018 |
|---|---|
| 221 | 227 |
| | |
| | |
| | |
| | |
| | |
| | |
| 185,222 | 190,778 |
| | |
| 185,442 | 191,006 |

# EXHIBIT S7

| SAINT FRANCIS Care<br><br>Policy and Procedure | **Title:**<br><br>**Communication: Language Services - including Limited English Proficient, Visually Impaired, Deaf or Hard of Hearing and Speech Impaired.** | | |
|---|---|---|---|
| ☒ Saint Francis Hospital and Medical Center<br>☒ Mount Sinai Rehabilitation Hospital<br>☒ Saint Francis Medical Group, Inc.<br>☒ Saint Francis *Care* Medical Group, P.C.<br>☒ Asylum Hill Family Medicine Center, Inc.<br>☒ Saint Francis Behavioral Health Group, P.C.<br>☒ Saint Francis Emergency Medicine Group, P.C. | **Proponent Department**<br><br>Patient Care | **Number**<br><br>CLIN.0121 | **Level**<br><br>☒ **System**<br>☐ **Division**<br>☐ **Department** |
| | **Category**<br><br>☐ **Administrative**<br>☒ **Clinical**<br>☐ **HR**<br>☐ **EOC** | **Published Date**<br><br>6/25/2015 | **Review Cycle**<br><br>☐ 1 year<br>☒ 3 years |

## PURPOSE:

The purpose of this policy is to help ensure quality Patient care by providing guidelines and procedures to assist Saint Francis Personnel (defined below) in providing Effective Communication (defined below) to individuals who are limited English proficient, visually impaired, deaf or hard of hearing, speech impaired, or who have any other disability impairing their ability to communicate (a "Language Service Need").

## SCOPE:

This policy applies to all Saint Francis Personnel in their communications with Patients or Companions (defined below) in all acute care and ambulatory clinical areas of the above referenced entities (collectively, "Saint Francis").

## DEFINITIONS:

1. The term **"Auxiliary Aids and/or Services"** includes, but is not limited to Qualified Interpreters in-person or through Video Remote Interpreting (VRI) services; note-takers; computer-assisted real time transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices and systems; telephone compatible hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text and video-based telecommunication products and systems, including text telephones (TTYs/TDDs), videophones and captioned telephones; or other methods of ensuring Effective Communication with individuals who are deaf or hard of hearing.

2. The term "**Companion**" means a person who is one of the following:

- a person whom the Patient designates to communicate with Saint Francis Personnel on his or her behalf regarding the Patient's condition or care or to help the Patient act on the information, advice or instructions provided by Saint Francis;
- a person legally authorized to make health care decisions on behalf of the Patient; or
- such other family member, friend, or associate of a Patient who, along with the Patient, is an appropriate person with whom Saint Francis should communicate.

3. The term "**Effective Communication**" means communication that is as clear and understandable to individuals with Language Service Needs as it is for individuals without. More specifically it means the successful joint establishment of meaning wherein Patients/Companions and health care providers exchange information, enabling

Patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both Patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from Patients, and when Patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care. For communication to be effective it must be, timely, provided in a manner and medium appropriate to the significance of the message and the communication abilities of the Patient/Companion.

4. The term "**Non-scheduled Request**" means a situation in which there is less than two (2) hours between the time when a Patient or Companion who is deaf or hard of hearing makes a request for an interpreter and when the services of an interpreter are necessary.

5. The term **"Patient"** means any individual who is seeking or receiving health care services (whether on an inpatient or outpatient basis, including consultations, treatment, scheduling of appointments, discussion of billing issues, attending health education classes, and other health care services) from Saint Francis.

6. The term **"Qualified Interpreter"** means an interpreter who, via a VRI service, telephone, or an onsite appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Qualified interpreters include, for example, sign language interpreters, oral transliterators, and cued-language transliterators. Not all interpreters are qualified for all situations. For example, an interpreter who is qualified to interpret using American Sign Language is not necessarily qualified to interpret orally. Someone who has only a rudimentary familiarity with sign language or finger spelling is not a "Qualified Interpreter" under this Agreement. Likewise, someone who is fluent in sign language but who does not possess the ability to process spoken communication into the proper signs or to observe someone else signing and change his or her signed or finger-spelled communication into spoken words is not a qualified sign language interpreter.

7. The term **"Scheduled Incident"** means situations in which there are two (2) or more hours between the time when an appointment is scheduled and when the services of the a Qualified Interpreter are required.

8. The term **"Saint Francis Personnel"** means all employees and independent contractors with contracts to work for Saint Francis, including, without limitation, nurses, physicians, social workers, technicians, admitting personnel, receptionists, telephone operators, billing staff, security staff, counselors, and therapists, and all volunteers, who have or are likely to have direct contact with Patients or Companions as defined herein. The term also includes all affiliated physicians or other health care professionals who have medical staff privileges that permit them to see and/or treat Patients at Saint Francis. Saint Francis will ensure that all Saint Francis Personnel receive training in Language Services appropriate to their role and level of direct contact with Patients and Companions.

9. The term **"Video Remote Interpreting" ("VRI")** means an interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed, wide-bandwidth video connection that delivers high-quality video images and meets other requirements as provided in 28 C.F.R. §36.303(f).

## POLICY:

### Commitment to Provide Effective Communication

Saint Francis shall provide its Patients and their Companions with Effective Communication and an equal opportunity to participate fully in the benefits, activities, programs and services provided by Saint Francis in a timely manner and in such a way as to protect the privacy and independence of the individual.

Where necessary to ensure Effective Communication, Saint Francis shall provide appropriate Auxiliary Aids and/or Services, including Qualified Interpreters, to Patients and Companions who are Limited English Proficient (LEP), visually impaired, deaf or hard of hearing, speech impaired or who have another disability which impairs their ability to communicate (collectively, "Language Service Needs"). Saint Francis shall make a site specific determination of which Auxiliary Aids and/or Services will be available at each of its separate locations.

Patients and Companions of Saint Francis, who are LEP shall have services provided to them in their primary language or have appropriate Auxiliary Aids and/or Services, including the services of a Qualified Interpreter provided to them during the delivery of all significant healthcare and related support services.

All Auxiliary Aids and/or Services shall be available within a reasonable time, at no cost to Patients as needed to provide Effective Communication.

## Assessment of Communication Needs:

**Assessment of Need for Auxiliary Aids and/or Services**. Saint Francis Personnel shall perform an assessment to determine whether the Patient or Companion requires Auxiliary Aids and/or Services to ensure Effective Communication ("Assessment of Language Needs"). If there is any indication from such initial assessment, inquiry, or Saint Francis Personnel's observations of the Patient or Companion, that the Patient or Companion has a Language Service Need, Saint Francis Personnel shall perform an assessment to determine which appropriate Auxiliary Aids and/or Services are needed in order to ensure Effective Communication. In determining which Auxiliary Aids and/or Services are necessary to ensure Effective Communication, and the timing, duration, and frequency with which they will be provided, Saint Francis Personnel shall consult with the Patient or Companion who has a Language Service Need. The assessment shall consider and take into account all relevant facts and circumstances, including without limitation the following:

- the Patient's or Companion's request for, stated need, or preference for, a Qualified Interpreter or other specific Auxiliary Aids and/or Services;
- the nature, length, complexity, and importance of the communication at issue;
- the individual's disability and communication skills and knowledge;
- the Patient's health status or changes thereto;
- the reasonably foreseeable health care activities of the Patient (e.g., medical tests or procedures, rehabilitation services, meetings with health care professionals or social workers, discussions regarding billing, insurance, self-care, prognoses, history, and discharge); and
- any factors relevant to determine whether the specific type of Auxiliary Aid and/or Service is effective under the circumstances as set forth below.

A list of communication options will be provided to the Patient/Companion to determine their preferred communication method(s). A Patient or Companion with a Language Service Need may prefer to use lip reading, paper and pencil or pictorial cards during the initial Assessment of Language Need.

**Timing of Assessment and Determination**. Saint Francis Personnel shall provide the initial Assessment of Language Needs at the first point at which a Patient accesses services at Saint Francis (emergency department registration, admissions, etc.). Saint Francis shall incorporate the Assessment of Language Needs into its electronic medical record and its intake procedures and document its determination in the patient's medical record, including substantially all of the elements set forth in the Communication Assessment and Waiver attached hereto as Attachment A. The Assessment of Language Needs shall be conducted at the earliest of the following:

- the time an appointment is scheduled;
- the time Saint Francis becomes aware that a Patient or Companion who has a Language Service Need

who may require Auxiliary Aids and/or Services is being transferred or transported to Saint Francis; or

- the time the Patient or Companion initially arrives at Saint Francis or encounters Saint Francis Personnel.

**Ongoing Assessment and Redetermination**. On an on-going basis, Saint Francis Personnel shall reassess their determination of whether Effective Communication is being provided, in consultation with the Patient or Companion who has a Language Service Need, when the Patient or Companion indicates that communication has not been effective, or when Saint Francis Personnel's observations suggest that communication has not been effective. The on-going Assessment of Language Needs shall be conducted during Patient care as needed and the Auxiliary Aids and/or Services shall be amended if required based on the findings of the on-going assessment.

**Continuation of Provision of Appropriate Auxiliary Aids and/or Services for Continued Hospitalizations and Subsequent Visits**. If a Patient or Companion who has a Language Service Need has an ongoing relationship with Saint Francis, with respect to each of the subsequent visits, Saint Francis shall continue to provide appropriate Auxiliary Aids and/or Services to the Patient or Companion during the entire period of the Patient's hospitalization and/or outpatient visits, without requiring subsequent assessments or requests for the appropriate Auxiliary Aids and/or Services by the Patient or Companion unless the Patient or Companion indicates otherwise.

**Documentation of Assessment and Determination**. The Assessment and determination of Language Needs shall be documented in the Patient's medical record. The Patient's medical record shall be conspicuously labeled to alert Saint Francis Personnel to the fact that the Patient or Companion has a Language Service Need and any Auxiliary Aids and/or Services that have been identified as necessary to Provide Effective Communication with the Patient or Companion.

**Determination Not to Provide Requested Auxiliary Aid or Service**. If, after conducting the Assessment of Language Needs, Saint Francis determines that it will not provide a particular Auxiliary Aid or Service requested by a Patient or Companion who has a Language Service Need, Saint Francis Personnel shall so advise the individual requesting the Auxiliary Aid or Service. In the event that an Auxiliary Aid or Service is necessary for Effective Communication and Saint Francis Personnel determine that they will not provide the Auxiliary Aid or Service requested by the Patient or Companion who has a Language Service Need, Saint Francis Personnel will secure and provide the Patient or Companion with another means of Effective Communication. Saint Francis Personnel shall document in the Patient's medical record the basis for the determination, including the date of the determination; the name and title of the Saint Francis Personnel who made the determination; and the alternative Auxiliary Aid or Service, if any, that Saint Francis provided.

**Exchange of written notes**. In determining whether the exchange of written notes, using either paper and pen or a mobile device, is Effective Communication under the circumstances, in addition to the factors listed above, relevant factors include the Patient's or Companion's fluency in written English.

**Lip Reading**. In some circumstances, lip reading may be a means of Effective Communication. In determining whether communication using lip reading is appropriate and Effective Communication under the circumstances, in addition to the factors listed above, relevant factors include:

- the Patient's or Companion's fluency in English;
- the Patient's or Companion's competency in lip reading; and
- whether the Patient or Companion has residual hearing.

**<u>Provision of Qualified Interpreter Services</u>**:

**Provision of Qualified Interpreter**. Saint Francis shall provide a Qualified Interpreter to a Patient or Companion whenever needed for Effective Communication. The following are examples of circumstances when it is necessary to provide Qualified Interpreters:

- Obtaining a Patient's medical history or description of symptoms and medical condition;
- Discussing or explaining a Patient's diagnosis, current condition, prognosis, treatment options or recommendation for treatment;
- Explaining Patient rights and responsibilities;
- Discussing or explaining procedures, tests, or treatments;
- Discussing or explaining test results;
- Discussing or explaining prescribed medications, instructions for how and when medication is to be taken, and possible side effects and interactions of medications;
- Obtaining informed consent or permission for procedures, surgery, or other treatment options;
- Communicating during treatment and testing;
- Communicating during discharge or post-operative planning and instruction;
- Providing mental health evaluations, group or individual therapy, counseling or other therapeutic activities, including, but not limited to, grief counseling and crisis intervention;
- Providing information about blood or organ donations;
- Explaining living wills or powers of attorney (or their availability);
- Discussing financial or insurance matters related to payment for services;
- Providing educational presentations, such as classes concerning birthing, nutrition, cardiopulmonary resuscitation (CPR), and weight management;
- Any other circumstance in which a Qualified Interpreter is necessary to ensure a Patient's rights provided by the law.

The foregoing list of circumstances is not exhaustive and does not imply that there are no other circumstances when it may be appropriate to provide Auxiliary Aids and/or Services for Effective Communication.

Acceptable methods for the provision of Qualified Interpreter and translation services include, but are not limited to the following:

- Telephone-based interpreting- delivered via telephonic technology
- Video Remote interpreting (VRI)- video conference with a Qualified Interpreter (including but not limited to American Sign Language (ASL))
- In-person interpreting- provided onsite by a Qualified Interpreter (including ASL)
- Written translation of vital and non-vital documents (vital documents as determined by the Joint Commission, Department of Health and Human Services and other regulatory agencies)

Whenever possible, arrangements for Qualified Interpreters/equipment should be made in advance when Patients have scheduled appointments. Telephone Qualified Interpreter services are available on each unit and will be used whenever appropriate if there is a delay in the delivery of resources. For deaf and hard of hearing Patients the VRI resources can be used if there is a delay in arrival of in-person resources.

The following resources and/or devices may be utilized at **no charge to the Patient.**

**A. <u>Deaf or Hard of Hearing</u>**

Pictorial Cards (located in the language resource box)
Amplified Handset/Volume Control Telephone

Large Button Telephones
Telephone Typewriter (TTY)
Video Remote Interpreter (VRI) (With Qualified Interpreter communication including but not limited to ASL)
Contracted onsite Qualified Interpreters (including but not limited to ASL)

**B. Visually Impaired**

Braille Telephones

**C. Limited English Proficient**

- Pictorial Cards (located in the language resource box)
- Telephone interpreting (telephone based language interpretation)
- Video Remote interpreting (including but not limited to ASL)
- In-person interpreting (including but not limited to ASL)
- Written translated documents

## Procedures for Obtaining Language Service Resources

**Procedure For Obtaining A Telephone Qualified Interpreter:**
If the Patient wishes to utilize the telephone Qualified Interpreter, Saint Francis Personnel will phone the hospital operator by dialing **'0'** from any phone and request to be connected to language resources. Dual handset phones are available on all units that are preprogrammed to dial language resources directly.

The requesting staff will provide the following information:

- Requestor's name and a call back telephone phone number
- Department name (including campus)/department code
- Telephone number
- Service and language requested
- Name of Patient
- Service or equipment needed
- Date, time, and approximate length of appointment
- Location (specific directions to the location)
- Where and who to report to
- Any special requirements

**Procedure For Obtaining A Video Remote Interpreter (VRI) Device:**
The requesting staff shall first make a determination as to whether communication using VRI is appropriate and effective. Relevant factors in making such determination include whether:

- The Patient or Companion is limited in his or her ability to see the video screen;
- The Patient or Companion has limited ability to move his or her head, hands, or arms; vision limitations, cognitive or consciousness issues, or pain issues;
- There are multiple people in a room and the information exchanged is highly complex or fast-paced;
- The Patient or Companion may move repeatedly to areas of Saint Francis that do not have a designated high speed internet line; and
- The Patient will be treated in a room where there are space restrictions.

1. If the requesting staff determines that VRI is appropriate, they shall phone the hospital operator, dial '0'

and request the VRI device be brought to the Patient.

The requesting Saint Francis Personnel shall provide the following:

- Name and telephone number of requester,
- Department - including campus and address,
- Patient name and reason for visit,
- Date, time and approximate length of time needed,
- Additional assistance that may be needed

2. The hospital operator will validate that the Patient is in an area that has wireless communication.

3. The hospital operator will notify the storeroom via phone to request the VRI device on behalf of the Patient.

4. The VRI device will be deployed to the requesting department within 10 minutes, if available. Storeroom staff will complete the storeroom VRI device log.

5. The equipment will be placed in a location that is easily viewed by both the Patient and the Saint Francis Personnel, generally near the foot of the bed or stretcher (or according to Patient abilities), with the Saint Francis Personnel standing near the Patient at the head of the bed during the interpretation session.

6. The Saint Francis Personnel will initiate the connection and answer a number of required questions such as Patient's name, medical record number, location, etc. before beginning the interpretation session.

7. Saint Francis Personnel shall ask the Patient or Companion whether the VRI is meeting his or her communication needs and make a record of the response in the medical record. In the event that the Patient or Companion cannot communicate effectively using any VRI service and alternative resource will be employed.

8. The VRI will facilitate communication between the Saint Francis Personnel and the Patient/Companion. NOTE:

a. The camera and sound system will pick up EVERYTHING that is said and done in the room and EVERYTHING will be interpreted to the Patient. There is no selective interpreting.

b. In the event of a system connectivity failure, the Saint Francis Personnel should notify the operator of equipment failure, the operator will request technical support and/or request a replacement VRI. In the event that a repair or replacement VRI is not available in a timely manner Saint Francis Personnel shall obtain an alternative means of Effective Communication in accordance with this policy or follow the procedures outlined below for Interim Services until a repair or replacement VRI is secured.

9. The same Patient may require the VRI device several times during a single hospital visit. The Saint Francis Personnel must disconnect at the end of each session or whenever they leave the room and reconnect as needed to start a new session.

10. The Saint Francis Personnel must document in the Patient's medical record each time the equipment is utilized with dates and start and stop times of each interpretation session and effectiveness of communication method.

11. When the VRI equipment is no longer required, the Saint Francis Personnel will place the VRI in the dirty laundry area for pick up by storeroom staff.

Saint Francis shall ensure that VRI services are provided in accordance with the following standards:

- real-time, full-motion video and audio over a dedicated, high-speed, wide-bandwith video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
- a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating Patient or Companion's face, arms, hands, and fingers, regardless of his or her body position;
- a clear, audible transmission of voices;
- ensure that the interpreter providing VRI is a Qualified Interpreter who is capable of communicating effectively with the Patient or Companion; and
- users of the technology and other involved individuals are adequately training so that they may quickly and efficiently set up and operate the VRI.

Once the VRI is operating, Saint Francis Personnel shall ask the Patient or Companion whether the VRI is meeting his or her communication needs and make a record of his or her response. In the event that the Patient or Companion cannot communicate effectively using any VRI service the Hospital elects to acquire and offer, Saint Francis shall make all reasonable efforts to locate an in-person Qualified Interpreter or other Auxiliary Aid or Service that will provide Effective Communication; periodically inform the Patient or Companion of the status of those efforts; and document the concern and the steps taken to locate a Qualified Interpreter.

**Procedure For Obtaining An In-Person Qualified Interpreter (including ASL):**
The requesting Saint Francis Personnel will phone the hospital operator, dial '0' to request in-person Qualified Interpreter services. Operators will schedule these services including in-person Qualified Interpreters and will provide requesting Saint Francis Personnel with approximate time of arrival. They may or may not be immediately available due to weather restrictions etc., however, all services will be provided within a two hours of Non-scheduled Requests. If an in-person ASL Qualified Interpreter is not available, the VRI will be used for ASL Interpretation and the reason why the in-person Qualified Interpreter was not available must be noted in medical record. In the event that an Auxiliary Aid and/or Service is necessary and Saint Francis Personnel determines that it will not provide a particular Auxiliary Aid and/or Service requested by the Patient or Companion who has a Language Service Need, the requesting Saint Francis Personnel shall document the basis for the determination, including the date of the determination, the name and title of the Saint Francis Personnel who made the determination, and the alternative Auxiliary Aid and/or Service, if any, that Saint Francis decided to provide, in an Auxiliary Aid and Service Log. A copy of this documentation shall be retained and a copy shall be provided to the Patient or Companion upon request.

The requesting Saint Francis Personnel will provide the following information:

- Requestor's name and a call back telephone phone number
- Department name (including campus)/department code
- Telephone number
- Service and language requested
- Name of Patient
- Service or equipment needed
- Date, time, and approximate length of appointment
- Location (specific directions to the location)
- Where and who to report to
- Any special requirements

The Saint Francis Personnel will document the arrival time of the Qualified Interpreter in the Patient's medical record

including the length of time for the interpretive session and effectiveness of the communication method. Each interpretive session must be documented separately. The same Patient may require the Qualified Interpreter several times during a single hospital visit, as additional communications are needed.

**Procedure for the Provision of Written Translations:**

1. Vital documents as defined by the Joint Commission and the Department of Health and Human Services will be translated and made available to Patients/Companions. These documents include but are not limited to:
    - Patient Rights and Responsibilities
    - Informed Consent
    - Advanced Directives
    - HIPPA Forms
    - Discharge Instructions
    - Release of Information
    - Notices pertaining to denial, reduction, modification or termination of services
    - Grievance forms

    Documents will be translated into each primary language used by more than 15% percent of the Patient population (each a "Frequently Utilized Language"). This will be assessed on an annual basis.

## Provision of Qualified Interpreters in a Timely Manner:

When an interpreter is necessary for Effective Communication, Saint Francis shall ensure that Qualified Interpreters are provided in a timely manner.

**Provision of Qualified Interpreter for Scheduled Incidents**. For Scheduled Incidents, when a Qualified Interpreter is necessary to ensure Effective Communication, Saint Francis shall make a Qualified Interpreter available at the time of the appointment. If a Qualified Interpreter fails to arrive for the appointment, Saint Francis shall immediately contact the Qualified Interpreter service or another resource to arrange for another Qualified Interpreter.

**Provision of Qualified Interpreter for Non-scheduled Requests**. For Non-scheduled Requests, Saint Francis shall make a Qualified Interpreter available as soon as practicable, but no later than (a) two (2) hours from the time the request for an in-person Qualified Interpreter is made or (b) within fifteen (15) minutes of the request for a Qualified Interpreter when providing a Qualified Interpreter through VRI.

**Interim Services**. Between the time a Qualified Interpreter is requested and the time a Qualified Interpreter arrives, Saint Francis Personnel shall continue to try to communicate with the Patient or Companion who is deaf or hard of hearing for such purposes and to the same extent as they would have communicated with an individual without a disability, using all methods of communications. Saint Francis shall inform such Patient (or a Companion, if such Patient is unavailable) of the current status of efforts being taken to secure a Qualified Interpreter on his or her behalf. This section is not intended to delay the provision of appropriate medical care and services.

**Provision of Qualified Interpreter throughout Hospitalization**. Saint Francis shall provide a Qualified Interpreter throughout the admission of a Patient as necessary to achieve Effective Communication with such Patient or their Companion.

## Communication Restrictions:

**Restricted Use of Minors to Facilitate Communication**. Saint Francis shall not rely on a minor accompanying a Patient or Companion to interpret or facilitate communications between Saint Francis Personnel and a Patient or

Companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public and where there is no Qualified Interpreter available.

**Limited Use of an Adult Accompanying a Patient or Companion to Facilitate Communication**. Saint Francis shall not require a Patient or Companion to bring another individual to interpret for him or her. Saint Francis Personnel may not rely upon an adult accompanying a Patient or Companion to interpret or facilitate communications between Saint Francis Personnel and a Patient or Companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no Qualified Interpreter available or unless the following four factors are present:

- where the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication and such person agrees to provide such assistance;
- such use is necessary or appropriate under the circumstances, giving appropriate consideration to any privacy and confidentiality issues that may arise;
- the Patient or Companion has been made aware of Saint Francis's full range of Auxiliary Aids and/or Services available free of charge; and
- the Patient or Companion provides written confirmation, substantially in the form of the Waiver of Interpreter Services Provided by Saint Francis attached hereto as Attachment A, that he or she was made aware of relevant Auxiliary Aids and/or Services available free of charge and agrees to the use of such person to interpret or facilitate communication. In such situations, Saint Francis shall retain the above-required written documentation in the Patient's medical record.

## Notices:

Saint Francis shall develop, and post in conspicuous locations, notices that advise Patients and their families of the availability of Qualified Interpreters, the procedure for obtaining a Qualified Interpreter and the telephone numbers where complaints may be filed concerning Qualified Interpreter service problems, including, but not limited to, a T.D.D. number for the hearing impaired. All areas of first Patient contact shall be equipped with Language Determination Cards to assist Patients in identifying the Patient's primary language if communication barriers prevent Saint Francis Personnel from effectively determining the language of the Patients/Companions.

## Training

New employees of Saint Francis will be trained in the procedure for the acquisition of Qualified Interpreter services during their employee orientation. Training on this procedure for current Saint Francis Personnel is required on an annual basis via on-line Health Stream training. In-person training is available on request to all Saint Francis departments, units and programs that require further assistance. Quarterly trainings will be held for the operators to ensure they are updated on all language services. Operators will fulfill the 24/7 requirement of an in-person language services point-person (with Clinical Resource Coordinators as back up) when the Language Services Program Administrator is off-site.

A poster outlining the availability of language services has been installed at all nursing stations and other points of Patient registration throughout the hospital and The Language Services Program Administrator (defined below), or his/her designee, shall conduct bi-monthly audits of such signage to ensure it remains in place and updated as necessary.

The Language Services Program Administrator shall conduct an annual review of the Language Services Needs of the Patient population. Following such review, the Language Services Program Administrator shall update the list of Frequently Utilized Languages and recommend any necessary changes to this policy.

### Language Services Program Administrator

Saint Francis has designated a program administrator (the "Language Services Program Administrator"). The

Language Services Program Administrator, or his/her designee shall be available twenty-four (24) hours a day, seven (7) days a week, to answer questions and provide appropriate assistance regarding immediate access to, and proper use of, the appropriate Auxiliary Aids and/or Services, including Qualified Interpreters, required by this policy. The Program Administrator may be reached at (860) 714-7004 or, for non-urgent enquiries, via email @ [*EMAIL ADDRESS*]. Auxiliary Aids and/or Services can be requested by dialing the Saint Francis operator (860) 714-4000 or "0" internally. Additional information on language services may be found on the Language Services website, by clicking the "3+1 Language Services Program" icon on the Saint Francis Infonet.

## STATUTORY, REGULATORY OR OTHER REFERENCES/POLICY CROSS REFERENCE:

Section 504 of the Rehabilitation Act of 1973
Title III of the Americans with Disabilities Act (ADA)

## CROSS REFERENCES:

Disability Discrimination Complaint and Grievance Policy

**APPROVED BY:** Policy requires Vice President approval.

| Vice President(s): | Date: | Committee(s), if applicable: | Date: |
|---|---|---|---|
| Patti LaMonica, R.N. M.S.N.<br>Interim Vice President<br>Professional Nursing Practice and Quality Interim Chief Nursing Officer<br>Executive Director Emergency and Pre-hospital Service Line | 6/25/2015 | Surendra P. Khera MD MSc<br>Vice President, Medical Affairs<br>Chief Medical Officer \|Chief Quality Officer<br>Vice-Chair, Department of Medicine. | 6/25/2015 |

## REPLACES:

Communication: Language Services - including Limited English Proficient, Visually Impaired, Deaf or Hard of Hearing and Speech Impaired, 4/16/2015

## KEY CHANGES:

Procedures for request of services broadened and clarified.

Attachment A

## Communication Assessment and Waiver

It is the policy of Saint Francis to provide Auxiliary Aids and/or Services free of charge to ensure effective communication with Patients and Companions who are deaf, are hard of hearing, or have speech disabilities. We ask these questions so we may communicate effectively with you.

Patient's Name: _____

Name of Person with Disability (if not Patient): _____

Completed by:_____Date & Time:_____am/pm

Nature of Disability:

- ❏ Deaf
- ❏ Hard of Hearing
- ❏ Speech Disability
- ❏ Other (explain) _____

Relationship to Patient:

- ❏ Self
- ❏ Family Member
- ❏ Friend
- ❏ Other (explain) _____

Is a Qualified Interpreter necessary to assist in communicating with Hospital staff?

❏ Yes. Choose type:

❏ American Sign Language (ASL)

❏ Signed English

❏ Oral interpreter

❏ Cued speech

❏ Other (explain) _____

❏ No. Choose one:

❏ I do not use sign language or do not use an interpreter.

❏ I prefer to have family members/friends help with communication.

❏ I do not feel an interpreter is necessary or do not want one for this visit.

❏ Other (explain) _____

**If you select No, please complete the Waiver of Interpreter Services (below).**

**All Communication Services will be provided FREE OF CHARGE.**

If you requested an interpreter, do you have a preference between an in-person interpreter or a VRI?

❏ Yes, I prefer an interpreter in-person.
❏ Yes, I prefer video remote interpreter.
❏ No, I do not have a preference between the two.

Are other Auxiliary Aids and/or Services necessary for assisting with communication? Select all that apply:

❏ TTY/TDD (text telephone)
❏ Assistive listening device (sound amplifier)
❏ Qualified note-takers
❏ Exchange of written notes (writing back-and-forth)
❏ Relay
❏ CART (Computer-assisted Real Time Transcription Service)
❏ Other (explain) _____

If you have any questions, please call_____(voice),_____(TTY).

Signature_____Date & Time _____ Relationship to Patient_____

WAIVER OF INTERPRETER SERVICES PROVIDED BY SAINT FRANCIS

It is your choice whether you use an interpreter provided by Saint Francis. You are indicating that Saint Francis has offered to provide you with an interpreter, free of charge, and that you have declined Saint Francis offer.

❏ I waive my right to request that [*name of facility*] provide me an interpreter for this specific encounter.

❏ I have been informed of range of auxiliary aids and services that are available free of charge.

❏ I have been informed that [*name of facility*] does not require a Patient or Companion to bring someone to interpret for him or her.

❏ I request that_____(name of individual to interpret for Patient or Companion) to interpret or facilitate communications between [*name of facility*] personnel and the Patient or Companion.

Signature_____Date & Time _____ Relationship to Patient_____

If at any point during your Hospital visit, you wish to change any of the answers to the questions on this form or revoke your waiver, please notify_____.

# EXHIBIT S8

# The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review

**Glenn Flores**
Medical College of Wisconsin

## Abstract

Twenty-one million Americans are limited in English proficiency (LEP), but little is known about the effect of medical interpreter services on health care quality. A systematic literature review was conducted on the impact of interpreter services on quality of care. Five database searches yielded 2,640 citations and a final database of 36 articles, after applying exclusion criteria. Multiple studies document that quality of care is compromised when LEP patients need but do not get interpreters. LEP patients' quality of care is inferior, and more interpreter errors occur with untrained ad hoc interpreters. Inadequate interpreter services can have serious consequences for patients with mental disorders. Trained professional interpreters and bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and outcomes. Evidence suggests that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when LEP patients have access to trained professional interpreters or bilingual providers.

Published in Medical Care Research Review

Med Care Res Rev **June 2005** vol. 62 no. 3 **255-299**

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE AL ADINOLFI
ONE HUNDRED AND THIRD ASSEMBLY DISTRICT

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JUDICIARY COMMITTEE
PUBLIC HEATH COMMITTEE
VETERANS' AFFAIRS COMMITTEE

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10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Dear Ms. Martone,

I am writing in support of Saint Mary's application to sell its assets to Trinity Health Corporation ("Trinity Health"), a non-profit, Catholic, multi-institutional healthcare system serving people and communities in 21 states. This will occur by joining with Saint Francis Care ("Saint Francis") as part of a Regional Health Ministry ("RHM") in Connecticut and Western Massachusetts.

As a legislator, my first concern is access to quality health care in the Waterbury area. Health care is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity, which has now joined forces with St. Francis Care, add Saint Mary's to its network will provide a financial base that is greatly needed.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Al Adinolfi

Representative Al Adinolfi
103rd District- Cheshire, Southington, and Wallingford

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# State of Connecticut

## HOUSE OF REPRESENTATIVES
STATE CAPITOL

**REPRESENTATIVE ROBERT SAMPSON**
EIGHTIETH ASSEMBLY DISTRICT

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**MEMBER**
COMMERCE COMMITTEE
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10/26/2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Representative Rob Sampson
80th District

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HEALTHCARE ACCESS

# State of Connecticut

## SENATE

**SENATOR HENRI MARTIN**
THIRTY–FIRST SENATE DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
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WEBSITE: www.SenatorHenriMartin.com

**SENATE MINORITY WHIP**

**RANKING MEMBER**
BANKS COMMITTEE
COMMITTEE ON CHILDREN
VETERANS' AFFAIRS COMMITTEE

**MEMBER**
TRANSPORTATION COMMITTEE

10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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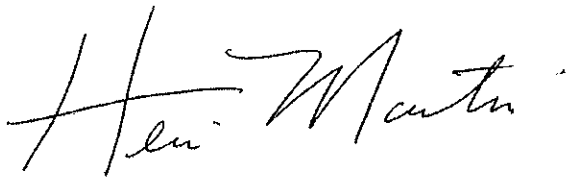
large hospital will put enormous pressures on the hospital in the near future. Saint Mary's has explored other options in terms of a partner, but believes that Saint Francis and Trinity offer the best match in terms of values, shared mission and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,



Senator Henri Martin
31st District

# 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

November 4, 2015

The Honorable Henri Martin
Senate Minority Whip
31st Senate District
State of Connecticut
Legislative Office Building, Suite 3400
Hartford, CT 06106-1591

Re: Certificate of Need
Saint Mary's application to sell its assets to Trinity Health Corporation

Dear Senator Martin:

On November 2, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Hospital to sell its assets to Trinity Health Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket once it is received. Please be advised, that once a hearing has been scheduled it will be posted on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
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# 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

November 4, 2015

The Honorable Al Adinolfi
Assistant Republican Leader
103rd Assembly District
State of Connecticut
Legislative Office Building, Room 4200
Hartford, CT 06106-1591

Re: Certificate of Need
Saint Mary's application to sell its assets to Trinity Health Corporation

Dear Representative Adinolfi:

On October 26, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Hospital to sell its assets to Trinity Health Corporation.

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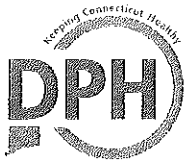


Connecticut Department of Public Health

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# 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

November 4, 2015

The Honorable Robert Sampson
Representative
80th Assembly District
State of Connecticut
Legislative Office Building, Room 4200
Hartford, CT 06106-1591

Re: Certificate of Need
Saint Mary's application to sell its assets to Trinity Health Corporation

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# State of Connecticut

## SENATE

SENATOR HENRI MARTIN
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RANKING MEMBER
BANKS COMMITTEE
COMMITTEE ON CHILDREN
VETERANS' AFFAIRS COMMITTEE

MEMBER
TRANSPORTATION COMMITTEE

10/22/15

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

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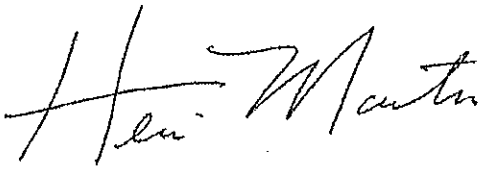

Senator Henri Martin
31st District

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# State of Connecticut

## HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE ROBERT SAMPSON
EIGHTIETH ASSEMBLY DISTRICT

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INSURANCE AND REAL ESTATE COMMITTEE

MEMBER
COMMERCE COMMITTEE
JUDICIARY COMMITTEE

10/26/2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

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Sincerely,

Representative Rob Sampson
80th District

State of Connecticut

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HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE AL ADINOLFI
ONE HUNDRED AND THIRD ASSEMBLY DISTRICT

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ASSISTANT REPUBLICAN LEADER

MEMBER
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JUDICIARY COMMITTEE
PUBLIC HEATH COMMITTEE
VETERANS' AFFAIRS COMMITTEE

10/22/15

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Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Sincerely,

Al Adinolfi

Representative Al Adinolfi
103rd District- Cheshire, Southington, and Wallingford

**ST. FRANCIS XAVIER RECTORY**
**625 BALDWIN STREET**
**WATERBURY, CONNECTICUT 06706**
**(203) 756-7804 ◦ Fax (203) 756-7805**

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HEALTHCARE ACCESS

November 12, 2015

Kimberly R. Martone, Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

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Trinity Health as well as Saint Francis Care and Saint Mary's are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church. For a number of years, Saint Mary's has searched for a partner capable of providing the support necessary so that Saint Mary's facilities, services, and programs can continue to be operated on an efficient and financially sound basis in order to maintain their continued quality of care, viability, and availability for patients in their service area.

The health care environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis Care, together with their ultimate acquisition by Trinity, will give both Catholic hospitals the support that is needed to be successful. Together, they plan to improve the infrastructure and capabilities required to deliver value-based accountable care, improve population health, enhance the quality of care, reduce the cost of healthcare, expand services, and support physician alignment and initiatives.

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I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation.

Respectfully submitted,

Rev. Paul J. Pace
Pastor

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

RECEIVED
NOV 9 2015
HEALTHCARE ACCESS

REPRESENTATIVE CRAIG A. MINER
SIXTY-SIXTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

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Craig.Miner@housegop.ct.gov

DEPUTY REPUBLICAN LEADER

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LABOR AND PUBLIC EMPLOYEES COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

November 6, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Healthcare Access
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone:

I write today in strong support of Saint Mary's Hospital application to sell its assets to Trinity Health Corporation.

As a legislator, I know that many of my constituents have greatly benefitted from the dedicated service that the medical professionals at Saint Mary's Hospital have given them over the years. The approval of this acquisition will allow Saint Mary's to continue serving so many within our community with the backing of Trinity Health Corporation.

The health care industry has changed greatly in recent years and smaller, independent hospitals will struggle in the future to deliver the same caliber of care that they have in the past. By merging with Saint Francis Care, and then with both eventually being acquired by Trinity Health Corporation, Saint Mary's can look to the future with a strong partner.

Thank you for your consideration of this request. If I can be of any further assistance in this matter, please do not hesitate to contact my office.

Sincerely,

Craig Miner
*State Representative*
*66th District*

NOSS

Neurosurgery, Orthopaedics
& Spine Specialists, PC

Neurosurgery

Michael E. Karnasiewicz, MD, ABNS
*Neurosurgery & Spine Care*

Jarob N. Mushaweh, MD, ABNS
*Neurosurgery & Spine Care*

Alan S. Waitze, MD, ABNS
*Neurosurgery & Spine Care*

John G. Strugar, MD
*Neurosurgery & Spine Care*

David L. Forshaw, MD
*Neurosurgery & Spine Care*

Judith L. Gorelick, MD, FAANS, FACS
*Neurosurgery & Spine Care*

Orthopaedics

Glenn G. Taylor, MD, ABOS
*Orthopaedic Surgery & Spine Care*

William F. Flynn, Jr., MD, ABOS
*Joint Reconstruction & Sports Medicine*

Frederick J. Watson, MD, ABOS
*Orthopaedic Surgery & Sports Medicine*

Pain Management
and Rehabilitation

Tamer B. Ghaly, MD
*Interventional Pain Management*

Thomas Mathew, MD
*Interventional Physiatry*

Alisa H. Darling, MD, ABPMR
*Physical Medicine & Rehabilitation*
*Electrodiagnostic Medicine*

Mark A. Mashia, DC, MS
*Chiropractic Physician, Acupuncture*

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HEALTHCARE ACCESS

November 12, 2015

Kimberly R. Martone
Director of Operations
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application seeking approval for Saint Mary's Health System and its subsidiaries to be acquired as part of Trinity Health Corporation.

Dear Ms. Martone,

As a member of the medical staff of Saint Mary's Hospital, I want to express my support for the CON application filed by Saint Mary's to join Saint Francis Hospital in a Regional Health Ministry (NE-RHM) operated by Trinity Health, a non-profit, Catholic-based health system. As a non-profit Catholic healthcare system, Trinity shares the values and philosophy of Saint Mary's. At the same time, Trinity has the size and experience of operating in a large complex health care network, and the resources that a stand-alone hospital does not have. Trinity currently operates 86 hospitals in 21 states.

Healthcare reimbursement is changing on both the federal and state levels, and hospitals have to do more with less, as they evolve into an environment that focuses on health and wellness while also continuing to care for the sick. The $100 million dollar investment Trinity will make in Saint Mary's over five years will, in part, be used for community health/population management initiatives, physician network development and infrastructure development. These investments will allow Saint Mary's to improve the delivery of quality care as it fulfills its community-based mission.

As a physician practicing within Saint Mary's existing health network, I look forward to the potential for improvement in quality while expanding our capability to serve patients in our service area. Upgrading the Hospital's infrastructure will also benefit all of the physicians who have privileges at Saint Mary's Hospital. If this application is approved, it will allow Saint Mary's physicians access to explore clinical relationships with Yale as part of the ACO currently operated by Saint Francis HealthCare Partners, which is developing "Total Health", an alliance with Yale New Haven Health System.

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Satellite Offices Shelton, CT - Southbury, CT - Torrington, CT
Phone (203) 755-NOSS (6677) (800) 463-8764
Fax Neurosurgery: (203) 573-9182 Orthopaedics: (203) 755-7166 Spine/physiatry: (203) 573-1272
Web www.nossmd.com

I recognize the challenges that a hospital faces as it tries to serve more people with less revenue. Changes evolving from the federal Patient Protection and Affordable Care Act require that health providers focus on wellness, and provide health services directly related to the community's need, while continuing to provide quality care for the sick and those brought in for emergency treatment at the hospital. Trinity will provide Saint Mary's with resources, both medically and monetarily, to move into the future on solid ground.

I strongly recommend that you approve the application submitted by Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., Trinity Health Corporation and the Regional Health Ministry formed in CT by Trinity and Saint Francis Care, Inc.

Sincerely,

David L. Forshaw, M.D.

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE LARRY B. BUTLER
SEVENTY-SECOND ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
HARTFORD, CT 06106-1591

CAPITOL: 860-240-8585
TOLL FREE: 800-842-8267
E-MAIL: Larry.Butler@cga.ct.gov

CO-CHAIR
HOUSING COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
HUMAN SERVICES COMMITTEE

RECEIVED
NOV 27 2015
Office of
HEALTHCARE ACCESS

November 24, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, Connecticut 06134

Re: Saint Mary's Health System's Certificate of Need Application

Dear Ms. Martone,

I am writing in support of Saint Mary's Health System's application to sell its assets to Trinity Health Corporation, which is a non-profit, Catholic, multi-institutional healthcare system that serves communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, one of my concerns is the access to quality healthcare throughout the Waterbury region. Healthcare is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity Health Corporation, which has now joined forces with Saint Francis, will make Saint Mary's stronger and more capable of meeting the needs of the community.

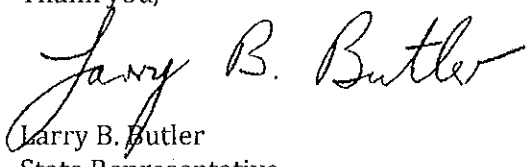
The healthcare environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis, together with their ultimate acquisition by Trinity Health Corporation, will give both Catholic hospitals the support that is essential to be successful. Together they plan to improve the infrastructure and capabilities required to deliver value-based accountable care; improve population health; enhance the quality of care; reduce the cost of healthcare; expand services; and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent, and capital to keep the safety network for healthcare alive and well. While Saint Mary's is a strong hospital, the demands of the new healthcare laws and high cost of

technology necessary to run a large hospital will put enormous pressure on the establishment in the near future. Saint Mary's has explored other options in terms of a partner, however I believe that Saint Francis and Trinity Health Corporation offer the best match in terms of values, shared mission, and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation

Thank you,



Larry B. Butler
State Representative

# 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

December 2, 2015

The Honorable Larry B. Butler
Representative -72nd District
House of Representatives
Legislative Office Building
Hartford, CT 06106-1591

Re: Certificate of Need Docket Number 15-32045-CON
Saint Mary's Health System
Saint Mary's application to sell its assets to Trinity Health-New England, Inc.

Dear Representative Butler:

On November 27, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Saint Mary's Health System's application to sell its assets to Trinity Health Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE LARRY B. BUTLER
SEVENTY-SECOND ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
HARTFORD, CT 06106-1591

CAPITOL: 860-240-8585
TOLL FREE: 800-842-8267
E-MAIL: Larry.Butler@cga.ct.gov

RECEIVED
NOV 27 2015
Office of
HEALTHCARE ACCESS

CO-CHAIR
HOUSING COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
HUMAN SERVICES COMMITTEE

November 24, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford, Connecticut 06134

Re: Saint Mary's Health System's Certificate of Need Application

Dear Ms. Martone,

I am writing in support of Saint Mary's Health System's application to sell its assets to Trinity Health Corporation, which is a non-profit, Catholic, multi-institutional healthcare system that serves communities in 21 states. This will occur by joining with Saint Francis Care as part of a Regional Health Ministry in Connecticut and Western Massachusetts.

As a legislator, one of my concerns is the access to quality healthcare throughout the Waterbury region. Healthcare is becoming more expensive while reimbursements from the government are shrinking. Having a non-profit entity like Trinity Health Corporation, which has now joined forces with Saint Francis, will make Saint Mary's stronger and more capable of meeting the needs of the community.

The healthcare environment has changed rapidly in the last few years, and stand-alone hospitals are finding it difficult to develop the resources necessary to offer quality care to all of their patients. This merger with Saint Francis, together with their ultimate acquisition by Trinity Health Corporation, will give both Catholic hospitals the support that is essential to be successful. Together they plan to improve the infrastructure and capabilities required to deliver value-based accountable care; improve population health; enhance the quality of care; reduce the cost of healthcare; expand services; and support physician alignment and initiatives.

We have known for a long time that Waterbury was going to need an extraordinary partner to infuse time, talent, and capital to keep the safety network for healthcare alive and well. While Saint Mary's is a strong hospital, the demands of the new healthcare laws and high cost of

technology necessary to run a large hospital will put enormous pressure on the establishment in the near future. Saint Mary's has explored other options in terms of a partner, however I believe that Saint Francis and Trinity Health Corporation offer the best match in terms of values, shared mission, and philosophy.

I strongly recommend that you approve the application before you submitted by Saint Mary's Health System and Trinity Health Corporation

Thank you,

Larry B. Butler

Larry B. Butler
State Representative

# 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: 15-32045-CON
Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.
Transfer of Ownership and Control to Trinity Health-New England, Inc.,
formerly known as Saint Francis Care, 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.

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

## Greer, Leslie

**From:** Schaeffer-Helmecki, Jessica
**Sent:** Thursday, December 24, 2015 2:32 PM
**To:** 'chartley@stfranciscare.org'; 'banthony@stmh.org'
**Cc:** Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
**Subject:** Request for more information
**Attachments:** 15-32045 Completeness Letter 12.24.15.pdf

Mrrs. Hartley and Anthony:

Attached please find a completeness request associated with docket number 15-32045, to transfer ownership of Saint Mary's Health System to New England Regional Health Ministry. Please confirm receipt of this e-mail.

Thank you,

**Jessica Schaeffer-Helmecki**
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

*Office of Health Care Access*

December 24, 2015

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Dadlez and Mr. Anthony:

On November 25, 2015, the Office of Health Care Access received a Certificate of Need application filing on behalf of Saint Mary's Health System ("SMHS") and New England Regional Health Ministry ("NE-RHM"), a subsidiary of Trinity Health Corporation ("THC"), for NE-RHM to acquire SMHS and its assets. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **February 22, 2016**, otherwise your application will be automatically considered withdrawn.

OHCA has reviewed the CON application pursuant to Connecticut General Statutes §19a-639a(c) and requests the following additional information:

1. What will the organizational structure resulting from this proposal be? Will, as stated on page 16, SMHS be either dissolved or restructured or merged with Saint Mary's Hospital? Provide an organizational chart that reflects this structure.

2. Will this affiliation impact Saint Mary's relationship with Waterbury Hospital in the Harold Lever Regional Cancer Center or the Heart Center of Greater Waterbury? Please explain.

3. Please submit the bylaws, referenced on page 112 of the application, of the resulting governing body.

4. According to CON 07-31003, Saint Mary's no longer has a neonatal program at the hospital, however the Applicant's outpatient data shown on page 60 includes Neonatal ICU discharges. Please explain this and what, if any, other hospitals' discharge data is included in historical and projected data.

5. What entity will be doing the billing for Saint Mary's if the CON is approved?

6. Which entity—Trinity Health or NE-RHM—has committed the $100 million capital expenditure to Saint Mary's, as referenced on page 21? Provide documentation of this commitment.

7. With respect to the $100 million capital expenditure and two additional $10 million payments:

    a) List all sources of funding and financing.
    b) What portion of the payment will be derived from Saint Mary's operational revenue?
    c) Is payment of the full $100 million amount contingent upon financial performance?
    d) Will Saint Mary's future income be:
        i. Used to fund the payment?
        ii. If so, in full or in part?
        iii. If Saint Mary's cannot fund the payment due to insufficient income, will the difference be made up? If so, how? Explain in detail.
    e) Is payment contingent upon any factors, such as meeting any revenue goals or benchmarks?
    f) How will the $100 million commitment be spent in each of the five years? Must Saint Mary's receive approval from NE-RHM or THC prior to spending the funds?
    g) Will financing from Trinity Health System's debt program, referenced on page 116 of the application, be used to fund the capital expenditure payment?

8. Regarding the additional $20 million NE-RHM may commit to SMHS based on an operating cash flow margin of 8% as indicated in the Transfer Agreement, please respond to the following:

    a) Is payment dependent upon SMHS or on Saint Mary's Hospital achieving the cash flow margin goal? If so, explain which entit(ies) must meet the goal.
    b) Is this the only financial metric that must be reached for the additional funding commitments or are there others and, if so, what are they?

c) Provide the cash flow margin of Saint Mary's and for SMHS for each of the past three years
d) If the margin is attained, is there a date certain when NE-RHM will provide the additional commitment? Explain in detail.
e) Are there specific projects the additional funding will be used for?

9. Regarding the $100 million needed for hospital facility upgrades, clinical equipment and strategic investments listed on page 82:

a) Are these the projects on which the $100 million capital expenditure contribution will be spent if the CON is approved? List the order in which the projects would be completed, with the first project listed as the most essential.
b) What will be done with the $12 million that is currently spent per year on routine capital purchases and how does this amount figure into the proposed capital spending needs of SMHS over the next 5 years?
c) What are the specific facility upgrades that are needed for $22 million?
d) What types of clinical equipment is going to be purchased for $18 million?
e) Explain the clinically integrated network development expenditure of $5 million.
f) Provide details on the $10 million to be used for urgent care/ambulatory care since $25 million is expected to be spent on a new pavilion.

10. What are the "new requirements" regarding the Applicant's charitable care policies and procedures referenced on page 82? How will the policies differ in comparison to current Saint Mary's policies? Please provide copies of the post-2016 policies.

11. Regarding the long term debt and the SMHS retirement plan, respond to the following:

a) Explain further the unfunded pension obligations including providing the current funded status of the plan.
b) Explain future plans to address the debt obligations including the rates being paid presently and the rates that would apply if the debt was refinanced.

12. What attempts have been made by SMHS to address the capital spending needs listed on page 82?

13. What attempts were made to restructure debt under the current management structure?

14. Provide the Fitch, Moody's and S&P credit ratings along with the date of the most recent credit rating for NE-RHM and Trinity Health.

15. Which entities are included in the NE-RHM financial worksheet data on page 441?

16. Page 432 indicates that based on Trinity Health's historical success in integrating hospitals and health systems into the Trinity Health System, cost savings of 1% of operating expenses have been achieved. Provide the following:

    a) List all hospitals THC has integrated into its system over the past three years.
    b) For each hospital listed above, list the savings achieved at each hospital and indicate what percentage of savings that represents.

17. Provide the dollar breakdown of projected future savings for Saint Mary's Hospital in the areas listed on page 432 (i.e., purchased supplies, supply chain, insurance and risk management, treasury, tax and compliance) for FY17, FY18 and FY19.

18. Page 440 indicates that "financial projections in FY 2016 – 2019 for Trinity Health New England don't include potential synergies to be realized as a result of the recently approved transaction between Trinity Health and Trinity Health New-England." Provide details and examples of these expected synergies.

19. Page 83 indicates that if the application is approved, future SMHS contract negotiations will be part of the broader New England Regional Health Ministry negotiations. What benefits are anticipated as a result?

20. The Transfer Agreement indicates on page 114 that NE-RHM will be charged system fees which will be allocated to the member hospitals. Provide details of the amounts SMHS will be charged for fees, explain if these fees have been accounted for in the financial projections and, if so, how?

21. On page 22, "physician partnerships" are cited as a contributing reason for the proposal. Please elaborate on this.

22. Page 41 states that particular focus will be on the Cancer, Joint Replacement and Cardiology service lines. What changes are planned for these service lines?

23. The Applicants state that SMHS will benefit from the proposal's implementation of electronic health records. Please explain the current health records system.

24. The Applicants state that there are no planned changes to the clinical services offered by SMHS or its subsidiaries as a result of this transaction. However, on page 85 the Applicants state that they will, "reduce costs through standardization of clinical protocols and clinical integration . . . these efforts will likely result in the elimination of duplicate services."

a) List the services offered by SMHS that are anticipated to require changes and the parties involved in this decision.
b) Indicate what services will likely be eliminated.

25. Respond to the following questions regarding the Financial Worksheets on pages 434-437 for Saint Mary's Hospital and SMHS. Explain why:

a) The amount for "Other Deductions" (Line A4) increases by more than 100% from FY2015 to FY2016.
b) Other Operating Revenue remains the same in FYs 2016 – 2019.
c) There are no self-pay revenues provided in any of the years.
d) Interest expense decreases approximately 80% in the FY 2016 – FY 2019 projections from the amounts reported in FY 2015.

If you have any questions concerning this letter, please feel free to contact either me at (860) 509-8075 or Ron Ciesones at (860) 418-7030.

Sincerely,

Jessica Schaeffer-Helmecki
Jessica.schaeffer-helmecki@ct.gov
Planning Analyst

## Greer, Leslie

**From:** Hartley, Christopher <CHartley@stfranciscare.org>
**Sent:** Thursday, December 24, 2015 2:36 PM
**To:** Schaeffer-Helmecki, Jessica; 'banthony@stmh.org'
**Cc:** Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; Rotavera, Liz
**Subject:** RE: Request for more information

I have received the e-mail.
Merry Christmas and Happy New Year.
Chris Hartley

---

**From:** Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
**Sent:** Thursday, December 24, 2015 2:32 PM
**To:** Hartley, Christopher; 'banthony@stmh.org'
**Cc:** Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
**Subject:** Request for more information

Mrrs. Hartley and Anthony:

Attached please find a completeness request associated with docket number 15-32045, to transfer ownership of Saint Mary's Health System to New England Regional Health Ministry. Please confirm receipt of this e-mail.

Thank you,

**Jessica Schaeffer-Helmecki**
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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| | |
|---|---|
| **From:** | Attorney Bob Anthony |
| **To:** | "Hartley, Christopher"; Schaeffer-Helmecki, Jessica |
| **Cc:** | Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; "Rotavera, Liz" |
| **Subject:** | RE: Request for more information |
| **Date:** | Thursday, December 24, 2015 2:36:48 PM |

---

I also received the email. Thank you. Happy holidays.

Bob Anthony

Sent with Good (www.good.com)

-----Original Message-----
**From:** Hartley, Christopher [CHartley@stfranciscare.org]
**Sent:** Thursday, December 24, 2015 02:35 PM Eastern Standard Time
**To:** Schaeffer-Helmecki, Jessica; Attorney Bob Anthony
**Cc:** Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie; Rotavera, Liz
**Subject:** RE: Request for more information

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Merry Christmas and Happy New Year.
Chris Hartley

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**From:** Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
**Sent:** Thursday, December 24, 2015 2:32 PM
**To:** Hartley, Christopher; 'banthony@stmh.org'
**Cc:** Riggott, Kaila; Ciesones, Ron; Fernandes, David; Greer, Leslie
**Subject:** Request for more information

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Thank you,

**Jessica Schaeffer-Helmecki**
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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Saint Mary's HOSPITAL Trinity Health New England

January 29, 2016

Via Hand Delivery

RECEIVED
JAN 29 2016
Office of HEALTHCARE ACCESS

Jessica Schaeffer-Helmecki
Planning Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Completeness Responses for the Certificate of Need Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis Care, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find the original and CD containing our responses to OHCA's December 24, 2015 letter regarding the above referenced Certificate of Need application.

If you have any questions regarding this response please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573.

Sincerely,

By: _____
Robert Anthony
General Counsel
Saint Mary's Health System

By: _____
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc.

Enclosures

January 29, 2016

Via Hand Delivery

Jessica Schaeffer-Helmecki
Planning Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

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Sincerely,

By: _____
Robert Anthony
General Counsel
Saint Mary's Health System

By: _____
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc.

Enclosures

1. **What will the organizational structure resulting from this proposal be? Will, as stated on page 16, SMHS be either dissolved or restructured or merged with Saint Mary's Hospital? Provide an organizational chart that reflects this structure.**

   The entity known as Saint Mary's Health System will be dissolved leaving Saint Mary's Hospital (Saint Mary's) as the surviving entity. The Trinity Health - New England entity will replace Saint Mary's Health System as the sole member of Saint Mary's Hospital. **Exhibit 24** reflects the proposed structure.

2. **Will this affiliation impact Saint Mary's relationship with Waterbury Hospital in the Harold Lever Regional Cancer Center or the Heart Center of Greater Waterbury? Please explain.**

   Saint Mary's, along with Waterbury Hospital are both committed to ensuring that the services offered by the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury continue to be offered to the greater Waterbury community. We will continue to work collaboratively and do understand that any changes that fall under the purview of the CON statutes will require both organizations to appropriately notify OHCA.

3. **Please submit the bylaws, referenced on page 112 of the application, of the resulting governing body.**

   Please see **Exhibit 25** (Saint Mary's Health System Amended and Restated Certificate of Incorporation) and **Exhibit 26** (Saint Mary's Health System Amended and Restated Bylaws).

4. **According to CON 07-31003, Saint Mary's no longer has a neonatal program at the hospital, however the Applicant's outpatient data shown on page 60 includes Neonatal ICU discharges. Please explain this and what, if any, other hospitals' discharge data is included in historical and projected data.**

   CON 07-31003 gave Connecticut Children's Medical Center the approvals to operate an Inpatient Pediatric Medical Surgical Unit on the Saint Mary's Hospital Campus. The neonatal ICU program, which existed before CCMC became involved with Saint Mary's Hospital, and continues to be a Saint Mary's Hospital program supporting the hospital's maternity program, and was not included in this ruling. Please see **Exhibit 27** for the Agreed Settlement. No other hospital's discharge data is included in the historical and projected data.

5. **What entity will be doing the billing for Saint Mary's if the CON is approved?**

   Saint Mary's Hospital will continue to bill as it currently does. There is no anticipated change in Saint Mary's current billing practices related to this proposal.

6. **Which entity—Trinity Health or NE-RHM—has committed the $100 million capital expenditure to Saint Mary's, as referenced on page 21? Provide documentation of this commitment.**

As noted in Section 4.01 Capital Commitment of the Transfer Agreement between Trinity Health /NE-RHM and Saint Mary's ("Transfer Agreement"), "Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than $120,000,000 subject to the achievement of the performance metrics in years four and five, to support operations of Saint Mary's and Saint Mary's controlled subsidiaries." This $100M capital commitment is part of the $275M capital commitment Trinity Health made to Saint Francis Care, Inc. as noted in CON #15-31979-CON. Trinity Health is responsible to ensure the $275M capital commitment to Saint Francis Care, Inc. (now the NE-RHM) and the NE-RHM is responsible to ensure $100M of this capital is allocated to Saint Mary's. Please see **Exhibit 28** for the documentation of the commitment.

7. **With respect to the $100 million capital expenditure and two additional $10 million payments:**

   a) **List all sources of funding and financing.**

   The sources of funding as agreed to in Section 4.01 of the Transfer Agreement are:

   1. Available cash and investments generated by Saint Mary's;
   2. Financing obtained through the Trinity Health system debt program; and, to the extent necessary,
   3. Capital contributions from Trinity Health

   The goal of the NE-RHM is for its subsidiaries to support their capital investments with their own cash flow. If Trinity Health, NE-RHM and Saint Mary's determine that financing the capital investments is more prudent than utilizing Saint Mary's cash generated from operations then the NE-RHM will access the Trinity Health debt program on behalf of Saint Mary's. For example, despite Saint Mary's generating sufficient cash flow for these expenditures, NE-RHM, Trinity Health and Saint Mary's may determine it is more prudent to maintain its current cash position and instead finance Saint Mary's capital investments. In this case, the NE-RHM, through Trinity Health, would provide financing to Saint Mary's for these capital investments.

   b) **What portion of the payment will be derived from Saint Mary's operational revenue?**

   The $100M of capital allocated to Saint Mary's is not a payment. It is a commitment to ensure an allocation of capital investment to Saint Mary's. The $100M of capital will be funded as noted in 7a above.

   c) **Is payment of the full $100 million amount contingent upon financial performance?**

   The allocation of $100M of capital investment is not contingent upon Saint Mary's financial performance.

   d) **Will Saint Mary's future income be:**

**i. Used to fund the payment?**

Any of Saint Mary's cash flow can be used to pay for its capital expenditures as long as its use does not compromise Saint Mary's ability to fulfill its financial obligations.

**ii. If so, in full or in part?**

After review of the capital expenditure need and Saint Mary's balance sheet, it will be determined whether the capital expenditure will be funded by Saint Mary's cash flow partially or fully and, if only partially, the remainder of the capital expenditure will be financed using the Trinity Health debt program.

**iii. If Saint Mary's cannot fund the payment due to insufficient income, will the difference be made up? If so, how? Explain in detail.**

As noted in 7a above, if Saint Mary's cannot generate sufficient cash flow to fund a capital expenditure, the NE-RHM can obtain financing for the capital expenditure through the Trinity Health debt program.

**e) Is payment contingent upon any factors, such as meeting any revenue goals or benchmarks?**

As noted in paragraph 4.01 of **Exhibit 28**, only $20 million of the capital investment is contingent upon achieving financial performance metrics.

**f) How will the $100 million commitment be spent in each of the five years? Must Saint Mary's receive approval from NE-RHM or THC prior to spending the funds?**

The allocation would be determined after the closing of the transaction in conjunction with NE-RHM based on Saint Mary's capital needs and the NE-RHM strategic and current priorities. NE-RHM will follow the Trinity Health system capital approval process, which will require NE-RHM approval for capital expenditures. Capital expenditures will also be subject to the Trinity Health governance matrix, which dependent on the level of a particular capital expenditure may require Trinity Health management or governance approval. Trinity Health management approval is typically for capital expenditures greater than $5M but less than $25M and capital expenditures greater than $25M require Trinity Health governance approval.

**g) Will financing from Trinity Health System's debt program, referenced on page 116 of the application, be used to fund the capital expenditure payment?**

As deemed necessary by Trinity Health and NE-RHM, financing from Trinity Health System's debt program would be available to fund capital expenditures.

8. **Regarding the additional $20 million NE-RHM may commit to SMHS based on an operating cash flow margin of 8% as indicated in the Transfer Agreement, please respond to the following:**

   a) **Is payment dependent upon SMHS or on Saint Mary's Hospital achieving the cash flow margin goal? If so, explain which entit(ies) must meet the goal.**

   Payment is dependent upon the consolidated financial performance of Saint Mary's Hospital and its controlled subsidiaries achieving the operating cash flow margins as indicated in the Transfer Agreement.

   b) **Is this the only financial metric that must be reached for the additional funding commitments or are there others and, if so, what are they?**

   This is the sole financial metric used as a condition for the additional $10 million of capital allocation in year 4 and additional $10M of capital allocation in year 5.

   c) **Provide the cash flow margin of Saint Mary's and for SMHS for each of the past three years**

   SMHS generated operating cash flow margin of 7.7%, 7.6% and 4.9% for FY13, FY14 and FY15, respectively. The Hospital generated standalone operating cash flow margins of 9.5%, 12.7% and 12.1% for FY13, FY14 and FY15, respectively.

   d) **If the margin is attained, is there a date certain when NE-RHM will provide the additional commitment? Explain in detail.**

   As noted in the Transfer Agreement 4.01(b) and 4.01(c), respectively, $10M of additional capital commitment would be available in the 4th year following the effective date of Saint Mary's joining Trinity Health/NE-RHM if at least an 8% operating cash flow margin is obtained in the 3rd year following the effective date and likewise, $10M of additional capital commitment would be available in the 5th year following the effective date of Saint Mary's joining Trinity Health/NE-RHM if at least an 8% operating cash flow margin is obtained in the 4th year following the effective date. As an example, if the effective date of Saint Mary's joining Trinity Health/NE-RHM is 7/1/15, then if in the year ended 6/30/18 Saint Mary's and its controlled subsidiaries produce an operating cash flow margin of 8%, an additional $10M of capital will be allocated to Saint Mary's for the year ended 6/30/19.

e) **Are there specific projects the additional funding will be used for?**

There are currently none identified to date.

9. **Regarding the $100 million needed for hospital facility upgrades, clinical equipment and strategic investments listed on page 82:**

a) **Are these the projects on which the $100 million capital expenditure contribution will be spent if the CON is approved? List the order in which the projects would be completed, with the first project listed as the most essential.**

Yes, subject to approval by NE-RHM and/or Trinity Health. The projects have not yet been prioritized. That would happen after the transaction and in conjunction with the NE-RHM capital planning process.

b) **What will be done with the $12 million that is currently spent per year on routine capital purchases and how does this amount figure into the proposed capital spending needs of SMHS over the next 5 years?**

Saint Mary's will continue to spend capital as needed for routine equipment replacement and routine facility upgrades. These routine expenditures are part of the $100M of capital commitment.

c) **What are the specific facility upgrades that are needed for $22 million?**

At this time, it is expected that Saint Mary's Hospital facility will require upgrades to its primary back-up generator, electrical power switching gear, along with planned replacements of two chillers and a series of area-specific air handling units. Additionally, three elevators are slated for replacement in addition to necessary nursing unit upgrades and modernization. Further, it is expected that the Holiday Inn will be demolished and replaced with an ambulatory pavilion.

d) **What types of clinical equipment is going to be purchased for $18 million?**

At this time, planned upgrades include two new fluoroscopy imaging units, a house-wide telemetry and patient monitoring upgrade, a real-time location tracking system for critical clinical equipment, operating room furnishing upgrades, upgraded breast imaging technology, and upgrades to support transition to single bed patient rooms.

e) **Explain the clinically integrated network development expenditure of $5 million.**

This is an estimate of certain IT costs to integrate providers for purposes of coordinating care management throughout our communities.

f) **Provide details on the $10 million to be used for urgent care/ambulatory care since $25 million is expected to be spent on a new pavilion.**

At this time, it is expected that the $10 million will be used to develop urgent care (and related services (e.g. diagnostic x-ray and lab draw) in the communities we serve. As an example, Saint Mary's has announced that it plans to build a new urgent care center, primary care office and physical therapy center in Naugatuck by 2017. Please see **Exhibit 29** for the announcement. Further, it is planned that a new pavilion ($25 million) may be developed on the hospital campus to provide ambulatory surgery (currently off campus) and other hospital services.

**10. What are the "new requirements" regarding the Applicant's charitable care policies and procedures referenced on page 82? How will the policies differ in comparison to current Saint Mary's policies? Please provide copies of the post-2016 policies.**

Trinity Health, NE-RHM and Saint Mary's are all committed to charity care consistent with their respective charitable missions and core values. Emergency medical care services are required to be provided to all patients who present to the emergency department, without regard to the patient's ability to pay. Trinity Health, NE-RHM and all RHMs provide financial support to medically indigent patients. Saint Mary's policies are consistent with both Trinity Health and the NE-RHM.

Trinity Health and its hospitals, including Saint Francis Hospital and Medical Center ("Saint Francis"), comply with the requirements of Internal Revenue Code Section 501(r) applicable to tax exempt hospitals. In FY 2016, additional requirements are effective and require hospitals to ensure their policies and procedures address items such as extraordinary collection efforts, notification requirements for presumptive eligibility, application periods and processing requirements, financial assistance documentation requirements and communication requirements (e.g., plain language).

Saint Mary's policy provided in the original CON at Exhibit S4 (page 696) is Saint Mary's current policy. In addition, Saint Francis current policy was provided in the original CON, Exhibit 20 page 494. No changes have been made to these policies since the original filing.

Once Saint Mary's joins NE-RHM, Saint Mary's staff will have access to the NE-RHM and the system office for advice and assistance in further implementing financial assistance opportunities for patients and ensuring compliance with these requirements.

**11. Regarding the long term debt and the SMHS retirement plan, respond to the following:**

**a) Explain further the unfunded pension obligations including providing the current funded status of the plan.**

The underfunded pension liability per the September 30, 2015 audited financial statements, which notes Saint Mary's estimated plan liabilities in excess of plan assets was $75.9M.

**b) Explain future plans to address the debt obligations including the rates being**

**paid presently and the rates that would apply if the debt was refinanced.**

There are no immediate plans to restructure Saint Mary's debt at closing. Additional analysis will be completed to determine if an intercompany loan will be used to pay-off or refinanced Saint Mary's current outstanding debt post-closing. Please reference response to Question 13 for the current debt rates.

**12. What attempts have been made by SMHS to address the capital spending needs listed on page 82?**

Saint Mary's has not made any formal attempts to secure funding through bonds or loans from banking institutions for capital projects listed on page 82.

**13. What attempts were made to restructure debt under the current management structure?**

Saint Mary's refinanced its CHEFA debt in April 2015. Saint Mary's secured a $15 million bank loan and used approximately $5 million in debt service funds to call and extinguish the CHEFA Bonds. The Series E CHEFA Bonds ranged from 5-6% interest. The bank loan is for five years with $250k due in principal each month having an interest rate of LIBOR plus 110 basis points (approximately 1.5% total).

**14. Provide the Fitch, Moody's and S&P credit ratings along with the date of the most recent credit rating for NE-RHM and Trinity Health.**

NE-RHM does not have a separate credit rating. The most recent credit ratings for Trinity Health are as follows:

- Moody's – Aa3, stable outlook, 12/21/15
- S&P – AA-, stable outlook, 12/23/15
- Fitch – AA, negative outlook, 12/30/15

**15. Which entities are included in the NE-RHM financial worksheet data on page 441?**

The entities included in the NE RHM are:
Saint Francis Care, Inc. (now known as Trinity Health- New England, Inc.)
Saint Francis Hospital and Medical Center, Inc. and Subsidiaries
Mount Sinai Rehabilitation Hospital
Saint Francis Hospital and Medical Center Foundation, Inc.
Saint Francis Medical Group, Inc. and Subsidiary
Asylum Hill Family Medicine, Inc.

**16. Page 432 indicates that based on Trinity Health's historical success in integrating hospitals and health systems into the Trinity Health System, cost savings of 1% of operating expenses have been achieved. Provide the following:**

**a) List all hospitals THC has integrated into its system over the past three years.**

Please see response in Question 16b below.

**b) For each hospital listed above, list the savings achieved at each hospital and indicate what percentage of savings that represents.**

Trinity Health's most recent system-level merger with Catholic Health East leveraged the capabilities and expertise of both organizations. The resulting scope and scale has yielded more than $285 million of synergies since the Catholic Health East/Trinity Health consolidation in May 2013, with more than $25 million additional synergies planned through the fiscal year ended June 30, 2016. Actual and forecasted synergies are through initiatives such as renegotiating national vendor contracts, centralizing data center operations, combining our two insurance captives, reducing third party administrator fees, insourcing work related to compliance, internal audit and tax, and through growth and standardization initiatives. Trinity Health reported operating expenses of $13.9B in FY 2015, therefore realizing synergies savings of 1.8% of operating expenses.

Savings have also been realized in other significant Trinity Health acquisitions of local health systems and hospitals:

St. Joseph Health, Inc. ("SJH") is located in Syracuse New York– Effective date 7/1/15 – SJH has only been part of Trinity Health for a short period of time but over the last six months, SJH has realized approximately $4M of savings related to integrating SJH into Trinity Health insurance programs (combined brokers, reduction of duplicate administrative costs, etc.), reducing supply expense and lowering the cost of debt service. Additionally, joining the Trinity Health debt program has also created benefits such as less administrative burden related to debt financing for local SJH management and eliminating debt issuance timing risk (the risk of accessing the debt market in a high rate environment). This $4M savings as a percentage of SJH $700M of annual operating expense is 0.6%.

Saint Francis Care, Inc. (SFC) – Effective date 10/1/15 – SFC has only been part of Trinity Health for one quarter. See response to 18 below for some opportunities anticipated to be realized.

**17. Provide the dollar breakdown of projected future savings for Saint Mary's Hospital in the areas listed on page 432 (i.e., purchased supplies, supply chain, insurance and risk management, treasury, tax and compliance) for FY17, FY18 and FY19.**

Since this proposed transaction is still in the pre-approval stage, the type of information and analysis that is able to be performed is limited and, therefore, prevents the organizations from getting into specifics with respect to future savings. The areas identified in original CON are those areas where Trinity Health hospitals have historically realized benefits post close. Based on historical savings achieved by other

health systems after joining Trinity Health (refer to response to #16 above), the organizations anticipate achieving a 1% reduction in consolidated SMHS operating expenses by year two post-close. As noted in the response to #18 below, Saint Francis expects to achieve similar savings once efforts are fully implemented.

**18. Page 440 indicates that "financial projections in FY 2016 – 2019 for Trinity Health New England don't include potential synergies to be realized as a result of the recently approved transaction between Trinity Health and Trinity Health New-England." Provide details and examples of these expected synergies.**

Saint Francis has only been part of Trinity Health for one quarter and the identification of cost savings and other opportunities is ongoing. Based on initial analysis preformed to date, we anticipate starting to realize savings over the next eighteen months and the annual impact of these items is approximately:

- $4.0 million in annual savings relating to utilizing Trinity's group purchasing organization
- $2.0 million in software costs
- $760,000 interest expense
- $600,000 depreciation expense
- $300,000 in revenue cycle costs

Total annualized savings upon implementation of these efforts are $7,660,000, approximately 1% of Saint Francis operating expenses. Saint Francis also anticipates that it will save approximately $3.0 million in capital costs over the next two years due to better pricing under Trinity contracts. This reduced capital expense will result in a reduction in annual depreciation expense as noted above.

In addition to the above synergies, as of October 1, 2015, Saint Francis Hospital and Medical Center defeased $246 million in outstanding CHEFA bonds utilizing proceeds from an intercompany loan from Trinity Health. In addition, a fixed pay interest rate swap was transferred to Trinity Health. This transfer resulted in a $44 million reduction of Saint Francis' liability related to the interest rate swap, which strengthened Saint Francis' balance sheet by increasing its unrestricted net assets. Furthermore, the results of the debt refinancing with the intercompany loan, resulted in a reduction in interest expense as well as eliminated future interest rate risks.

**19. Page 83 indicates that if the application is approved, future SMHS contract negotiations will be part of the broader New England Regional Health Ministry negotiations. What benefits are anticipated as a result?**

Saint Mary's will benefit from being part of the broader NE-RHM and its contracts. Cost reductions from NE-RHM contracts are expected for items such as medical supplies, blood products, information technology and management contracts as a result of being part of a much larger healthcare system.

**20. The Transfer Agreement indicates on page 114 that NE-RHM will be charged system fees which will be allocated to the member hospitals. Provide details of the amounts SMHS will be charged for fees, explain if these fees have been accounted for in the financial projections and, if so, how?**

These amounts have not been included in the financial projections. Shared system office services include Revenue Excellence, Treasury, Human Resources, Supply Chain Management and Information Technology. These shared services are charged to Saint Mary's by the NE-RHM using an appropriate metric once an organization begins to access the benefits of these system departments. The NE-RHM will be charged for its share of these services and the NE-RHM will determine appropriate allocation, if any, to the entities within the RHM.

**21. On page 22, "physician partnerships" are cited as a contributing reason for the proposal. Please elaborate on this.**

Physician partnerships are contributing reason for the proposal as Saint Mary's strives to grow its physician enterprise. Over the past year and a half, Saint Mary's has formed Valley Health Alliance, an accountable care organization that has recently started working on shared savings program with Medicare. In addition, the ACO has begun a program with Anthem for those patients that are employees of Saint Mary's. This type of physician partnership requires additional management, staffing, data analysis and clinical oversight; areas where Saint Mary's needs more support. This is especially true as the number of physician partners continues to grow and as the shared savings programs are implemented. Saint Mary's could use the additional resources offered by NE-RHM whose physician enterprise is more equipped to handle these physician partnerships.

**22. Page 41 states that particular focus will be on the Cancer, Joint Replacement and Cardiology service lines. What changes are planned for these service lines?**

Saint Francis Hospital and Medical Center (Saint Francis), which is part of the NE-RHM, provides market leading Cancer, Joint Replacement and Cardiology services. Saint Francis's Cancer program is affiliated with Yale New Haven Health's Smilow Cancer Hospital, a premier research and treatment cancer institute. This proposal will allow for Saint Mary's to have better access to ground breaking clinical trials, provide broader screening and diagnostic tools, access to additional treatment options, increased psychosocial support and improved pain management therapies. Along with the high quality Radiation Therapy provided by the Harold Leever Cancer Center, patients in the Greater Waterbury area will benefit from this proposal. Saint Francis's Connecticut Joint Replacement Institute ("CJRI") is nationally recognized as a pioneer in reducing costs, improving quality and improving the patient experience. Saint Mary's collaboration with Saint Francis at adopting these advanced techniques can only stand to improve the joint replacement care in the Greater Waterbury market. Saint Mary's will benefit from the collaboration with Saint Francis's Hoffman Heart Institute. With one of the largest heart bypass and cardiac catheterization programs in the region, along with the national recognition from both the American Heart Association and American College of Cardiology, Saint Mary's will be able to adopt many of the techniques that made the institute nationally recognized. Trinity Health, with its 86 hospitals, will also provide the potential to learn and adopt best practices from hospitals leading the nation in these three services.

**23. The Applicants state that SMHS will benefit from the proposal's implementation of electronic health records. Please explain the current health records system.**

Currently Saint Mary's utilizes the McKesson Paragon EHR. While an adequate industry EHR, the NE-RHM's EPIC EHR system more seamlessly integrates inpatient, ambulatory and physician electronic medical information.

**24. The Applicants state that there are no planned changes to the clinical services offered by SMHS or its subsidiaries as a result of this transaction. However, on page 85 the Applicants state that they will, "reduce costs through standardization of clinical protocols and clinical integration . . . these efforts will likely result in the elimination of duplicate services."**

Costs reduction will be obtained from adopting best practices such as those exhibited by Saint Francis's CJRI program. CJRI has been able to reduce complication rates, reduce hospital length of stays, reduce pain and allow for a quicker recovery time so that patients may return to full function sooner. As Saint Mary's collaborates with NE-RHM, processes can be streamlined and others may be enhanced. Some examples may include medical supply purchase processes, provider recruitment, clinical program enhancements, clinical service benchmarking, call coverage contracts and medical equipment purchasing. In no manner does an elimination of duplicative services refer to clinical programs, rather it refers to the operational management of these services.

The language on page 85 is associated with the Lean Management approach. NE-RHM employs this organizational efficiency and quality approach, most notably associated with the Toyota Production System Manufacturing to many of its processes. A key component of this Lean Management approach is to focus on standardization of work to eliminate duplicative steps and thereby eliminate waste. A similar process is associated at UTC's through its Ito University. Once Saint Mary's becomes part of NE-RHM, many of its clinical protocols will be compared to those used by the NE-RHM. NE-RHM will standardize the way care is delivered at each clinical service site where possible. (A sample project illustrates the kind of standardization and reducing variations in care initiative that Trinity Health would engage in as part of this synergy. Reducing the wastage and unnecessary use of blood products (such as blood transfusions) not only is a process and resource drain but also poses health risks to patients from unnecessary transfusions. Trinity Health has a standardized process and protocol around when and how to use blood products. Implementation of this protocol would result in improved care, less waste and better health of our patients.)

There are no plans to eliminate any clinical services at Saint Mary's as a result of this application. However, an efficiency analysis, as noted above, will be completed for each clinical area once Saint Mary's has joined Trinity Health-New England.

This effort is time consuming and different for each clinical service. No timeline has been established for this work and a plan and related timeline will not be developed until after SMHS is officially part of NE-RHM.

**a) List the services offered by SMHS that are anticipated to require changes and the parties involved in this decision.**

See the answer to Question 24 above.

**b) Indicate what services will likely be eliminated.**

See the answer to Question 24 above.

**25. Respond to the following questions regarding the Financial Worksheets on pages 434-437 for Saint Mary's Hospital and SMHS. Explain why:**

**a) The amount for "Other Deductions" (Line A4) increases by more than 100% from FY2015 to FY2016.**

Other Deductions includes the net position of the Hospital Provider Tax offset by expected supplemental payments. At the time of our original assumptions, the State reduced all supplemental payments for SFY16. We assumed supplemental payments would resume in SFY 17, which is the 4th quarter of our FY16. Therefore, the estimated net tax position increased to $9.7M for FY16. We assumed no change in supplemental payment or hospital tax base in FY17-FY19.

**b) Other Operating Revenue remains the same in FYs 2016 – 2019.**

Other Operating Revenue assumptions include decreases in Meaningful Use from Medicare and Medicaid which is offset by increases in other areas such as Cafeteria, Rent, Child Care, Grants and Net Assets Released From Restriction.

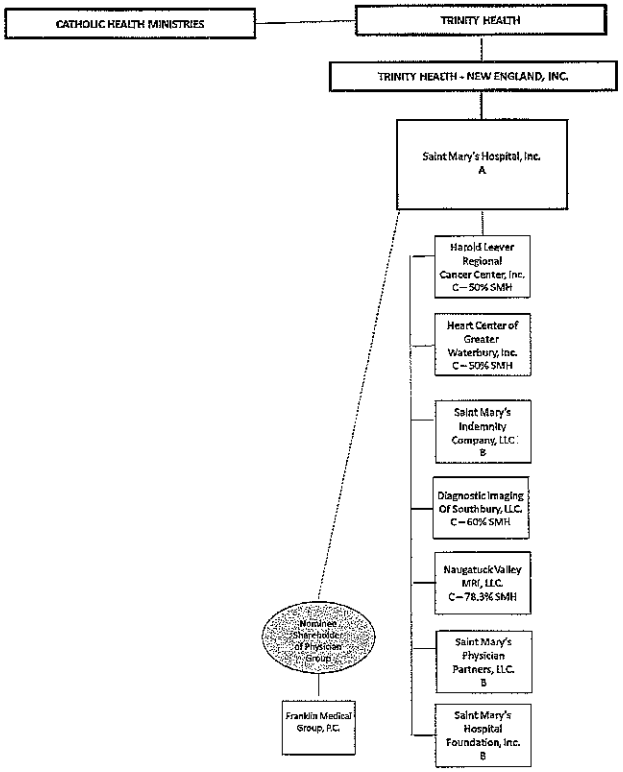
**c) There are no self-pay revenues provided in any of the years.**

See updated projections **Exhibit 30**. The net revenue by payor percentage was originally spread based on actual cash collections, however, bad debt expense should have been factored in, as the formula in the spread sheet is before bad debts. We note that self-pay net revenues are included in the uninsured category.

**d) Interest expense decreases approximately 80% in the FY 2016 – FY 2019 projections from the amounts reported in FY 2015.**

Saint Mary's refinanced its CHEFA debt in April 2015 saving approximately $1.0 million annually in interest costs. See response to Question 13 for further details.

# EXHIBIT 24




A Direct Subsidiaries of THNE
B Direct Subsidiaries of A entities
C Shared entities – reflecting the ownership Percentages of SMH

01/22/2016/Legal/CHS-Trinity/Org Charts/DRAFTS/DRAFT THE and SMH ONLY

# EXHIBIT 25

**Restated Certificate of Incorporation of Saint Mary's Hospital, Inc.**

A Connecticut Nonstock Corporation

1. The present name of the Corporation is Saint Mary's Hospital, Inc., which was incorporated on April 11, 1907.

2. This Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

3. The text of the Restated Certificate of Incorporation is as follows:

## ARTICLE I

### Name

The name of the Corporation is Saint Mary's Hospital, Inc.

## ARTICLE II

### Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Code of Regulations, System Authority Matrix, Bylaws or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

## ARTICLE III

### Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To carry out the purposes of Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successor, which is the Member of the Corporation, and to further the apostolate of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States;

B. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which, in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Trinity Health and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

C. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

D. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

E. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

F. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

G. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this

Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

H. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

I. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) of the Code (or, if the Corporation is classified, Section 509(a)(1) or 509(a)(2) of the Code).

## ARTICLE IV

### Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

## ARTICLE V

### Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Saint Francis Care, Inc., a Connecticut nonstock corporation.

## ARTICLE VI

### Registered Office and Resident Agent

The address of the Corporation's registered office is _____. The resident agent of the Corporation is _____. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

## ARTICLE VII

### Membership

Saint Francis Care, Inc., a Connecticut nonstock corporation ("Member") is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member and Trinity Health under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member and Trinity Health, as required, shall have exercised their respective reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member and Trinity Health:

a. As reserved to the Member:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonstock corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

b. As reserved to Trinity Health:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common

Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business.

## ARTICLE VIII

### Indemnification and Standard of Care

Section 1. Indemnification. The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, religious congregations or other canonical persons serving as sponsors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a trustee, director, religious congregation or other canonical person serving as sponsor, officer, manager, partner, employee, committee member, or agent of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 2. Insurance. Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person who is or was a member, director, trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of the Corporation, or who is or was serving at the request of the Corporation as a trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have power to indemnify him or her against such liability under state law.

Section 3. Standard of Care. Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, and with

such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 4. Justifiable Reliance. In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

a. One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.
b. Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.
c. A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.
d. A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 5. Consideration of Factors. In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 6. Presumption. Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation.

Section 7. Personal Liability of Director. No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

## ARTICLE IX

### Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

## ARTICLE X

### Effective Date of This Restated Certificate of Incorporation

This Restated Certificate of Incorporation is effective as _____, 201_.

# EXHIBIT 26

BYLAWS

OF

SAINT MARY'S HOSPITAL, INC.

A CONNECTICUT NONSTOCK CORPORATION

Effective Date: _____, 201_

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## Article I. DEFINITIONS

For the purposes of these Bylaws, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Control" or "Ownership" will be deemed to exist:

> (i) as to a corporation: (a) through ownership of the majority of voting stock or the ownership of the class of stock which exercises reserved powers, if it is a stock corporation; or (b) through serving as member and having the power to appoint (including through appointing one's own directors or officers who then serve ex officio as to the Affiliate) the majority of the voting members or the class of members which exercises reserved powers, if it is a corporation with members; or (c) through having the power to appoint (including through appointing one's own directors or officers who then serve *ex officio* as to the Affiliate) the majority of the voting directors or trustees or the controlling class of directors or trustees, if it is a corporation without members; or
>
> (ii) as to a partnership or other joint venture: through the possession of sufficient controls over the activities of the partnership or joint venture that the entity having control is permitted to consolidate the activities of the partnership or joint venture on its financial statements under generally accepted accounting principles.

The terms "Controlled," "Controlling," "Owned" or "Owning" shall be subsumed within the definitions of "Control" or "Ownership."

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Key Bylaws Provisions" shall refer to sections of these Bylaws that concern any of the following: (a) the name and corporate purposes of the Corporation; (b) the Catholic Identity and Mission and Core Values of the Corporation and the powers exercisable by CHM; (c) the identity of, reserved powers exercisable by, and other matters pertaining to, the Member and Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Board of Directors of the Corporation.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Operating Unit" shall have the definition set forth in Section 5.04 of these Bylaws.

"Regional Health Ministry" or "RHM" is an Affiliate or operating division within the Health System that maintains a governing body that has day to day management oversight of a designated portion of the Health System, subject to certain authorities that are reserved to Trinity Health. RHMs may be based on a geographical market or dedicated to a service line or business.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, a copy of which is attached and incorporated into these Bylaws as Exhibit A, and as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

## Article II. PURPOSES

### Section 2.01 Purposes

The purposes of the Corporation are set forth in the Certificate of Incorporation of the Corporation.

### Section 2.02 Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time).

### Section 2.03 Mission Statement

The Mission and Core Values of the Corporation shall be as adopted and approved from time to time by Catholic Health Ministries. The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation. The mission statement of the Corporation shall be as follows:

*"We serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."*

The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation.

### Section 2.04 Alienation of Property

Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

## Article III. MEMBER

### Section 3.01 Sole Member

The sole member of the Corporation is Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successors or assigns.

**Section 3.02 Member Authority**

The following actions shall be reserved exclusively to the Member of the Corporation. Subject to the reserved powers of Trinity Health, the Member may initiate and implement any proposal with respect to any of the following, or if any proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approvals and other actions shall have been taken by the Member and Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the

Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

**Section 3.03 Reserved Powers of Trinity Health**

The following actions shall be reserved exclusively to Trinity Health. Trinity Health may initiate and implement any proposal with respect to any of the following, or if a proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approval and other actions shall have been taken by Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in accordance to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in Sections 3.02 and 3.03 of these Bylaws, or (iii) transfers in the ordinary course of business.

**Section 3.04 Meetings of the Member**

Meetings of the Member shall be held at the principal office of the Member or as otherwise provided in the bylaws of the Member at such time and date determined in accordance with the bylaws of the Member. Notice of meetings of the Member shall be given in accordance with the bylaws of the Member.

## Article IV. BOARD OF DIRECTORS

### Section 4.01 Duties and Powers

With the exception of the powers reserved to the Member, Trinity Health or Catholic Health Ministries under the Corporation's Governance Documents or applicable law, the Board of Directors shall govern, regulate and direct the affairs and business of the Corporation, carry out such policies and guidelines as adopted by the Member and Trinity Health and carry out such responsibilities as shall be delegated to it by the Member and Trinity Health, all in a manner consistent with the Mission and Core Values of the Corporation. Additional descriptions of the duties and powers of the Board of Directors are set forth in the System Authority Matrix. Among the matters under the direction of the Corporation's Board of Directors are the following actions:

(a) Elect the officers of the Corporation (except the President);

(b) Approve the Medical/Dental staff credentials for the hospital facilities owned and operated by the Corporation;

(c) Oversee the Corporation's relationship with the Medical/Dental staff as contemplated in Article V of these Bylaws;

(d) Adopt, amend, or repeal the Medical/Dental staff bylaws;

(e) Adopt and amend from time to time rules, regulations, and policies for the conduct of the operations and affairs of the Corporation;

(f) Develop and monitor the Corporation's quality improvement programs and approve quality and safety standards that shall be consistent with Trinity Health System quality and safety standards;

(g) Conduct an annual review of the Corporation's quality and safety performance; and

(h) Recommend to the Member or Trinity Health matters relating to the Corporation that require the approval or other action of the Member or Trinity Health pursuant to the Corporation's Governance Documents.

### Section 4.02 Appointments and Composition

The Member shall appoint a Board of Directors on the basis of qualifications and criteria established by the Member. Except as otherwise authorized by action of the Member, the members of the Corporation's Board of Directors shall include: (i) at least one representative of the Member, designated by the Member (who shall serve ex officio with vote) (the "Member Director"), and, unless the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation is designated as the Member Director, the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation

(who shall serve ex officio with vote), (ii) at least one physician, and (iii) members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community. Any exception to the Board composition requires the approval of the Member. The size of the Board shall be established by the Member, by policy or otherwise.

**Section 4.03 Term**

Directors shall serve a three-year term, or such shorter term as may be determined by the Member in order to achieve continuity in board composition. Ex officio members of the Board of Directors shall cease to be Directors upon the termination of their service in the office resulting in their ex officio service on the Board of Directors. Other than ex officio members, no Directors may serve for more than nine (9) consecutive years, unless appointed to complete the unexpired term of another Director, in which case a Director may serve for up to ten (10) consecutive years. Former Directors are eligible for reappointment after a one-year absence from service.

**Section 4.04 Annual Meeting of the Board of Directors**

An annual meeting of the Board of Directors shall be held at any time during the last six months of the calendar year for the purpose of the appointment of officers and the transaction of such other business as may properly come before the meeting. Notice of the annual meeting shall be given not less than ten (10) nor more than sixty (60) days before the date of the meeting. The meeting notice shall specify the date, time and place of the meeting. Presence at any such meeting shall be deemed to be waiver of notice of said meeting.

**Section 4.05 Regular Meetings and Notice**

Regular meetings of the Board of Directors shall be held as determined by the Board but no less frequently than quarterly at such time, place and date as determined from time to time by the Board of Directors. An agenda, indicating items requiring a vote of the members of the Board of Directors, together with copies of reports, statements and other supporting information shall be mailed by the Chief Executive Officer prior to meetings. No notice of regular meetings shall be required other than the resolution setting the time, place and date of the meeting.

**Section 4.06 Special Meetings and Notice**

Special meetings of the Board may be called by or at the request of the Chair, by written request of any two (2) members of the Board, or by the Member. The special meeting shall be held within five (5) days after receipt of such request. Notice of the special meeting shall be given in writing, personally, by telephone, electronic transmission or by facsimile transmission at least forty-eight (48) hours prior to the special meeting. The notice of any special meeting shall state the purpose for which it is called. No other business shall be transacted at the special meeting except for that business stated in the notice.

**Section 4.07 Waiver of Notice**

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Notice also may be waived in writing, either before or after the meeting.

**Section 4.08 Quorum and Valid Director Action**

At all meetings of the Board, a simple majority of the Directors then in office shall constitute a quorum for the transaction of business. The vote of a majority of the Directors present and voting at any meeting at which a quorum is present shall constitute the act of the Board, unless the vote of a larger number is specifically required by law, or by the Certificate of Incorporation, Bylaws or policies of the Corporation.

**Section 4.09 Written Consents**

Any action required or permitted to be taken by vote at any meeting of the Board or of any committee thereof may be taken without a meeting, if before or after the action, all members of the Board or committee consent in writing. The written consents shall be filed with the minutes of proceedings of the Board or committee. Such consents shall have the same effect as a vote of the Board or committee for all purposes.

**Section 4.10 Communication Equipment**

Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of teleconference, video conference or similar communications equipment by virtue of which all persons participating in the meeting may hear each other if all participants are advised of the communications equipment and the names of the participants in the conference are divulged to all participants. Participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

**Section 4.11 Resignation**

Any Director may resign by written notice to the Chair of the Board. The Chair of the Board may resign by written notice to the Corporation's President who shall promptly thereafter notify the entire Board of Directors. Resignations shall be effective upon receipt or at a subsequent time if specified in the notice of resignation.

**Section 4.12 Removal**

Any Director may be removed with or without cause at any time by the Member. Absences of a Director from three (3) consecutive regular meetings of the Board of Directors may constitute cause for removal from the Board of Directors.

**Section 4.13 Periodic Performance Review**

The Board of Directors shall periodically review its own performance and issue reports to Trinity Health summarizing the results of its review.

## Article V. MEDICAL/DENTAL STAFF

**Section 5.01 Medical/Dental Staff Bylaws**

The Medical/Dental staff of the hospital operated by the Corporation shall be organized pursuant to the bylaws of the Medical/Dental staff. The bylaws shall (i) describe the organization of the medical staff, (ii) describe the qualifications and criteria for Medical/Dental staff appointment and privilege determinations, (iii) state the duties and privileges of each category of the Medical/Dental staff, (iv) include procedures for recommendations by the Medical/Dental staff on the appointment of members of the Medical/Dental staff, the delineation of their staff privileges and the initiation of corrective action taken against any member, and (v) state the requirements for completion and documentation of patient histories and physical exams. The Medical/Dental staff bylaws also shall contain procedures for the resolution of disputes that may arise regarding the granting, denial or limitation of staff privileges or corrective action taken against any member of the Medical/Dental staff, including a hearing and appeal process and the circumstances in which such hearing/appeal rights will be made available. Bylaws, rules, regulations, and policies of the Medical/Dental staff may be proposed and adopted by the Medical/Dental staff of the hospital (or other health care provider that has a Medical/Dental staff), but the bylaws, rules, regulations, policies, and amendments thereto shall not become effective until approved by the Corporation's Board of Directors.

The Board of Directors shall have final responsibility for (i) appointment and reappointment of the members of the Medical/Dental staff and delineation of their staff privileges; (ii) taking such corrective action relating to Medical/Dental staff members as it deems appropriate; (iii) ratifying the selection of Medical/Dental staff officers made by the Medical/Dental staff; (iv) ratifying the selection of heads of the departments of the Medical/Dental staff; (v) reviewing and monitoring the quality improvement programs developed by the Medical/Dental staff; and (vi) determining which categories of practitioners are eligible for appointment to the Medical/Dental Staff. The Medical/Dental staff bylaws are not deemed to be a contract and are not intended to create contractual rights or responsibilities. The Board of Directors reserves the authority to take any direct action with respect to any Medical/Dental staff appointee action it deems to be in the best interests of the hospital operated by the Corporation, whether initiated by the Medical/Dental staff or not, and the decision of the Board shall be final.

**Section 5.02 Medical/Dental Staff of Operating Units**

The powers described in this Article V may be delegated to the governing body of an unincorporated operating division of governance and management of the Corporation

("Operating Unit") where such Operating Unit governing body is responsible for the operation of a hospital under applicable state law or standards of accrediting agencies. Such delegation may be accomplished by resolution or by setting forth the powers and duties of such governing body in the bylaws of the Operating Unit.

## Article VI. COMMITTEES

### Section 6.01 Committees

The Executive Committee of the Board of Directors and such other committees as state law may require shall be standing committees of the Corporation. The Board of Directors may establish such additional standing or special committees from time to time as it shall deem appropriate to conduct the activities of the Corporation and shall define the powers and responsibilities of such committees. Those other committees shall serve at the pleasure of the Board. The Corporation shall not have a separate audit committee as matters related to the audit of the Corporation's finances are consolidated at the Trinity Health level. The Board shall establish the purpose, composition, term and other operating matters relative to each such other committee. Each committee shall keep minutes in some manner reasonably intended to record the business that occurred at the meeting and shall forward these minutes to the Board of Directors.

### Section 6.02 Executive Committee

There shall be an Executive Committee, consisting of the Chair of the Board, who shall serve as chair of the Executive Committee, the Chief Executive Officer, and at least two (2) other Directors selected by vote of the Board of Directors. All members of the Executive Committee must be members of the Board of Directors. The Executive Committee shall meet on the call of the Chair or President. Except as otherwise provided by resolution of the Board or as limited by law, the Executive Committee shall exercise the power and authority of the Board when necessary or advisable between meetings of the Board and shall exercise such other powers as may be assigned from time to time by the Board. The Executive Committee shall report on its actions at the next meeting of the Board and such actions shall be subject to revision and alteration of the Board; provided, however, that the rights of third parties shall not be affected by any such revision or alteration.

### Section 6.03 Service on Committees

The committees shall establish rules and regulations for meetings and shall meet at such times as are necessary, provided that a reasonable notice of all meetings shall be given to committee members. No act of a committee shall be valid unless approved by the vote or written consent of a majority of its members. Committees shall keep regular minutes of their proceedings and report the same to the Board from time to time as the Board may require. Members of the committees (except the Executive Committee) shall be appointed for one (1) year by the Chair of the Board of Directors as soon as possible after the annual meeting of the Board. Members of the committees shall serve on their respective committees through the next annual meeting or until their successors are

appointed. The Chair of the Board shall fill vacancies on committees (except the Executive Committee) and appointees shall serve through the next annual meeting. The President shall be an ex officio member of all committees, except for any committee that reviews compliance or executive compensation matters.

**Section 6.04 Quorum, Meetings, Rules and Procedures**

A quorum for any meeting of a committee shall be a simple majority of the committee members or as otherwise required by applicable law, except that any ex officio members of the committee shall not be included in calculating the quorum requirement unless they are present at the meeting, in which event they shall be included towards meeting the quorum requirement. The affirmative vote of a majority of the quorum is necessary to take action of the committee, including the affirmative vote of at least one (1) member of the Board present at the meeting of the committee in order to take any action other than recommendation by the committee to the Board or Executive Committee. Minutes of all committee meetings shall be kept and forwarded to the Board. Each committee shall adopt rules for its own governance not inconsistent with these Bylaws or the acts of the Board.

**Section 6.05 Committee Composition**

The members and all chairs of committees other than the Executive Committee shall be appointed by the Chair of the Board. The chair of each committee shall be a Director. Committees, other than the Executive Committee, may include persons other than members of the Board of Directors; provided that each standing committee shall have at least two (2) Director members in addition to the Chair and Chief Executive Officer who shall serve ex officio; and provided further, that no authority of the Board may be delegated to a committee unless the majority of the members of such committee with Board delegated authority are members of the Board of Directors and otherwise in accordance with applicable law.

**Article VII. OFFICERS**

**Section 7.01 Officers**

The officers of the Corporation shall be the Chair, President, Secretary and Treasurer. Additionally, upon recommendation of the President, the Board of Directors may appoint a Vice Chair, an Assistant Secretary, an Assistant Treasurer, and such other officers of the Corporation as shall be deemed necessary and appropriate from time to time.. Officers shall hold their respective offices until their successors are chosen and qualified.

**Section 7.02 Appointment and Election of Officers**

The President of the Corporation shall be appointed, evaluated, reappointed and/or removed by the Member. The President shall be Chief Executive Officer of the Corporation and any vacancy in the office of President shall be filled by the Member. The Chair shall serve a term of one (1) year and may be elected for a total of three (3)

consecutive complete one year terms. The Chair, Treasurer and Secretary of the Corporation shall be elected at the annual meeting of the Directors by the Board of Directors. The Directors and Secretary need not be members of the Board.

**Section 7.03 Vacancies**

Vacancies, occurring for any reason, shall be filled in the same manner as appointment or election and the officer so appointed or elected shall hold office until a successor is chosen and qualified.

**Section 7.04 Chair**

The Chair shall preside at the Board meetings and shall be an ex-officio voting member of all committees.

**Section 7.05 President**

The President shall have general and active management responsibility for the business of the Corporation and shall see that all orders and resolutions of the Board of Directors and the policies of the Member are carried into effect, consistent with the Mission and Core Values of the Corporation. The President shall be responsible for the appointment, evaluation, compensation and removal of the respective executive officers of those corporations of which the Corporation is the member or other controlling shareholder or owner. The President shall be a voting ex officio member of all committees and shall have the general powers and duties of supervision and management usually vested in the office of President of a corporation.

**Section 7.06 Secretary**

The Secretary of the Corporation shall issue, or cause to be issued, notices of all Board meetings, shall be responsible for the keeping and the reporting of adequate records of all transactions of the Board, and shall record the minutes of all meetings of the Board of Directors. The Secretary shall further perform such other duties incident to his or her office and as the Board of Directors may from time to time determine.

**Section 7.07 Treasurer**

The Treasurer of the Corporation shall be responsible for all funds of the Corporation, shall make reports to the Board of Directors as requested by the Board of Directors, and shall see that an accounting system is maintained in such a manner as to give a true and accurate accounting of the financial transactions of the Corporation. The Treasurer shall further perform such other duties incident to his or her office as the Board of Directors may from time to time determine. The Treasurer may delegate any of the functions, powers, duties, and responsibilities to any agent or employee of the Corporation. In the event of such delegation, the Treasurer shall thereafter be relieved of all responsibility for the proper performance or exercise thereof.

## Article VIII. INDEMNIFICATION AND STANDARD OF CARE

### Section 8.01 Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons (including religious congregations and their members or other canonical persons and their members) who

(a) are serving or have served as members, trustees, directors, sponsors, officers, employees, committee or subcommittee members, or agents of the Corporation, or

(b) are serving or have served at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

### Section 8.02 Insurance

Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person (including religious congregations and their members or other canonical persons and their members) who

(a) is or was a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, or agent of the Corporation, or

(b) is or was serving at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not this Corporation would have power to indemnify him or her against such liability under state law.

### Section 8.03 Standard of Care

Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, the Member and Trinity Health, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

**Section 8.04 Justifiable Reliance**

In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

(a) One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.

(b) Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.

(c) A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.

A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

**Section 8.05 Consideration of Factors**

In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, the Member and Trinity Health, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation, the Member and Trinity Health are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

**Section 8.06 Presumption**

Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation, the Member and Trinity Health.

**Section 8.07 Personal Liability of Directors**

No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

## Article IX. SUBSIDIARIES AND VOLUNTARY HOSPITAL SERVICE ORGANIZATIONS

### Section 9.01 Authority

In accordance with policies of Trinity Health, including without limitation those referenced in the System Authority Matrix, each organization of which the Corporation is the sole or majority member or owner shall have reserved certain powers to be exercised by this Corporation.

### Section 9.02 Voluntary Hospital Service Organizations

The Board of Directors may authorize the establishment or dissolution of voluntary service organizations, such as an auxiliary to the Corporation or any Operating Unit of the Corporation. Such organization may be a non-profit corporation or voluntary association. No service organization may be established without approval of the Board of Directors, subject to the reserved powers of the Member and Trinity Health and any guidelines or policies established by Trinity Health with respect to voluntary organizations.

## Article X. OPERATING UNITS

### Section 10.01 Authority

The Board of Directors of the Corporation may organize the operations of the Corporation into one or more other Operating Units of governance and management that shall have such powers and shall carry out such responsibilities as shall be delegated to them pursuant to the policies of the Corporation and Trinity Health in effect from time to time.

## Article XI. MISCELLANEOUS

### Section 11.01 Fiscal Year

The fiscal year of the Corporation shall end on the 30th day of September of each year and shall begin on the 1st day of October of each year.

### Section 11.02 Required Records

The officers, agents and employees of the Corporation shall maintain such books, records and accounts of the Corporation's business and affairs as may be from time to time required by the Board of Directors, or required by the laws of the state in which the Corporation is domiciled.

**Section 11.03 Confidentiality**

Except as otherwise publicly disclosed, or in order to appropriately conduct the Corporation's business, the records and reports of the Corporation shall be held in confidence by those persons with access to them.

**Section 11.04 Conflict of Interest**

Each of the Corporation's officers and members of the Board shall at all times act in a manner that furthers the Corporation's charitable purposes and shall exercise care that he or she does not act in a manner that furthers his or her private interests to the detriment of the Corporation's community benefit purposes. The Corporation's officers and members of the Board shall fully disclose to the Corporation any potential or actual conflicts of interest, if such conflicts cannot be avoided, so that such conflicts are dealt with in the best interests of the Corporation. Conflicts of interest shall be resolved in accordance with the Corporation's conflict of interest policy. The Corporation and all its officers and members of the Board shall comply with any policies of the Corporation and Trinity Health regarding conflicts of interest, as well as the requirements of applicable state law regarding such conflicts, and shall complete any and all disclosure forms as may be deemed necessary or useful by the Corporation for identifying potential conflicts of interest.

**Article XII. AMENDMENT AND REVIEW**

**Section 12.01 Amendment**

These Bylaws may be amended only in accordance with Article III of these Bylaws.

**Section 12.02 Periodic Review**

These Bylaws shall be reviewed periodically by the Board of Directors and any recommended revisions shall be forwarded to the Member and Trinity Health for action.

EXHIBIT A

System Authority Matrix

# EXHIBIT 27

# Office of Health Care Access
# Certificate of Need Application

## Agreed Settlement

**Applicants:** Connecticut Children's Medical Center
Saint Mary's Hospital Corporation
Waterbury Hospital

**Docket Number:** 07-31003-CON

**Project Title:** Termination of Inpatient Pediatric Services at Saint Mary's Hospital and Waterbury Hospital and the Establishment and Operation of New Inpatient Pediatric Services at Saint Mary's Hospital by Connecticut Children's Medical Center

**Statutory Reference:** Section 19a-638, C.G.S.

**Filing Date:** January 23, 2008

**Hearing Date:** February 20, 2008

**Presiding Officer:** Cristine A. Vogel, Commissioner

**Decision Date:** May 1, 2008

**Default Date:** May 22, 2008 (30-day extension)

**Project Description:** Saint Mary's Hospital ("SMH") and Waterbury Hospital ("WH") propose to terminate inpatient pediatric services and Connecticut Children's Medical Center ("CCMC") proposes to establish, own, and operate inpatient pediatric services at Saint Mary's Hospital as a satellite facility at an estimated total capital expenditure of $600,079.

**Nature of Proceedings:** On January 23, 2008, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from Saint Mary's Hospital ("SMH") and Waterbury Hospital ("WH"), proposing to terminate inpatient

pediatric services, and Connecticut Children's Medical Center ("CCMC"), proposing to establish, own, and operate inpatient pediatric services at Saint Mary's Hospital as a satellite facility, at an estimated total capital expenditure of $600,079. CCMC, SMH and WH are health care facilities or institutions as defined by Section 19a-630, of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on February 20, 2008. On February 5, 2008, the Applicants were notified of the date, time, and place of the hearing. On February 2, 2008, a notice to the public announcing the hearing was published in *The Waterbury Republican-American.* Commissioner Cristine A. Vogel served as Presiding Officer. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

## Findings of Fact

**Clear Public Need**
**Impact of the Proposal on the Applicants' Current Utilization Statistics**
**Proposal's Contribution to the Quality of Health Care Delivery in the Region**
**Proposal's Contribution to the Accessibility of Health Care Delivery in the Region**

1. Connecticut Children's Medical Center ("CCMC") is a freestanding children's hospital located at 282 Washington Street in Hartford, Connecticut. It is licensed at 103 beds and 32 bassinets. *(July 13, 2007, Letter of Intent, page 19)*

2. Saint Mary's Hospital ("SMH") is a general hospital located at 56 Franklin Street, Waterbury. It is licensed at 347 beds and 32 bassinets. *(July 13, 2007, Letter of Intent, page 17)*

3. Waterbury Hospital ("WH") is a general hospital located at 64 Robbins Street, Waterbury. It is licensed at 357 beds and 36 bassinets. *(July 13, 2007, Letter of Intent, page 18)*

4. SMH and WH propose to terminate their inpatient pediatric services. CCMC proposes to establish, own, and operate new inpatient pediatric services within SMH. *(December 13, 2007, Initial CON Submission, page 2)*

5. CCMC will seek to have an additional satellite inpatient location, with 12 additional licensed medical/surgical beds, added to its existing Children's Hospital license issued by the State of Connecticut Department of Public Health. *(December 13, 2007, Initial CON Submission, pages 8 and 10)*

6. The following towns are within the service area of SMH and WH and account for over 90% of the pediatric admissions of the two hospitals in FY 2005, 2006, and 2007:

**Table 1: Towns within the Service Areas for SMH and WH**

| | | | | |
|---|---|---|---|---|
| Beacon Falls | Bethlehem | Cheshire | Middlebury | Morris |
| Naugatuck | Prospect | Southbury | Thomaston | Waterbury |
| | Watertown | Woodbury | Wolcott | |

*(December 13, 2007, Initial CON Submission, page 2)*

7. The population to be served includes the 56,746 children between birth and 18 years of age in the service area towns based upon the 2000 census; 24,252 of them reside in the city of Waterbury. *(December 13, 2007, Initial CON Submission, page 3)*

8. SMH currently staffs 209 of its 347 licensed beds, 12 are in the pediatric unit. WH currently staffs 265 of its 357 licensed beds, 10 are in the pediatric unit. *(December 13, 2007, Initial CON Submission, page 4)*

9. According to the Applicants, all pediatric inpatients will be admitted to the CCMC inpatient pediatric unit located within SMH. SMH and WH will no longer have pediatric inpatients as part of their patient volumes. The pediatric providers and support staff will be part of CCMC. CCMC pediatric medical and surgical specialists will be available for consultations as needed. *(December 13, 2007, Initial CON Submission, page 4)*

10. The following table reports the respective hospital's market share percentage for each town within the service area:

**Table 2: Market Share Analysis by Town and Hospital**

| | Market Share Percentage by Hospital | | | | | |
|---|---|---|---|---|---|---|
| **Town** | **CCMC** | **SMH** | **WH** | **Yale-NH** | **Others** | **Town Total** |
| Beacon Falls | 0.5% | 13.0% | 17.7% | 11.1% | 42.2% | 100% |
| Bethlehem | 0.0% | 15.5% | 56.0% | 2.9% | 74.4% | 100% |
| Cheshire | 0.8% | 10.8% | 6.8% | 23.9% | 42.4% | 100% |
| Middlebury | 0.7% | 20.9% | 53.9% | 7.1% | 82.7% | 100% |
| Morris | 0.2% | 9.4% | 24.5% | 4.5% | 38.5% | 100% |
| Naugatuck | 0.7% | 33.5% | 40.5% | 6.1% | 80.8% | 100% |
| Prospect | 1.3% | 40.4% | 34.8% | 8.4% | 84.9% | 100% |
| Southbury | 0.3% | 8.0% | 35.2% | 4.5% | 48.0% | 100% |
| Thomaston | 1.0% | 16.9% | 47.1% | 3.7% | 68.8% | 100% |
| Waterbury | 0.7% | 45.5% | 42.3% | 3.8% | 92.3% | 100% |
| Watertown | 0.9% | 21.3% | 62.8% | 4.0% | 89.0% | 100% |
| Woodbury | 1.1% | 45.0% | 29.8% | 3.6% | 79.5% | 100% |
| Wolcott | 0.6% | 12.8% | 47.6% | 6.0% | 66.9% | 100% |

Source: OHCA Hospital Inpatient Discharge Database FY 2007.

11. The units of service for the past three fiscal years by service area town for each hospital for children ages 0 to 18, excluding newborns, are reported in the following three tables:

**Table 3a: Service Utilization by Fiscal Year for CCMC**

| | Fiscal Year | | | |
|---|---|---|---|---|
| **Town** | **2004** | **2005** | **2006** | **2007*** |
| Beacon Falls | 2 | 5 | 1 | 2 |
| Bethlehem | 2 | 0 | 0 | 4 |
| Cheshire | 16 | 21 | 18 | 17 |
| Middlebury | 5 | 4 | 7 | 2 |
| Morris | 0 | 0 | 0 | 1 |
| Naugatuck | 28 | 31 | 17 | 30 |
| Prospect | 7 | 6 | 17 | 16 |
| Southbury | 5 | 6 | 10 | 5 |
| Thomaston | 9 | 8 | 9 | 6 |
| Waterbury | 108 | 119 | 96 | 126 |
| Watertown | 29 | 24 | 16 | 32 |
| Woodbury | 10 | 5 | 5 | 6 |
| Wolcott | 31 | 27 | 16 | 14 |
| **Total for Service Area** | **252** | **256** | **212** | **261** |

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

*(December 13, 2007, Initial CON Submission, page 40)*

**Table 3b: Service Utilization by Fiscal Year for SMH**

| | Fiscal Year | | | |
|---|---|---|---|---|
| **Town** | **2004** | **2005** | **2006** | **2007*** |
| Beacon Falls | 3 | 6 | 3 | 1 |
| Bethlehem | 1 | 2 | 1 | 1 |
| Cheshire | 5 | 6 | 4 | 10 |
| Middlebury | 11 | 11 | 8 | 8 |
| Morris | 1 | 3 | 0 | 0 |
| Naugatuck | 59 | 47 | 56 | 65 |
| Prospect | 23 | 13 | 6 | 22 |
| Southbury | 5 | 3 | 5 | 5 |
| Thomaston | 6 | 3 | 10 | 4 |
| Waterbury | 519 | 511 | 503 | 511 |
| Watertown | 30 | 28 | 21 | 35 |
| Woodbury | 8 | 7 | 4 | 11 |
| Wolcott | 20 | 24 | 21 | 36 |
| **Total for Service Area** | **691** | **664** | **642** | **709** |
| Other Towns | 33 | 53 | 48 | - |
| **Grand Total** | **724** | **717** | **690** | **-** |

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

*(December 13, 2007, Initial CON Submission, page 40)*

**Table 3c: Service Utilization by Fiscal Year for WH**

| | Fiscal Year | | | |
|---|---|---|---|---|
| **Town** | **2004** | **2005** | **2006** | **2007** |
| Beacon Falls | 4 | 2 | 3 | 4 |
| Bethlehem | 5 | 5 | 3 | 1 |
| Cheshire | 4 | 2 | 2 | 2 |
| Middlebury | 14 | 5 | 13 | 11 |
| Morris | 1 | 2 | 1 | 0 |
| Naugatuck | 64 | 62 | 42 | 42 |
| Prospect | 6 | 13 | 6 | 6 |
| Southbury | 12 | 4 | 8 | 6 |
| Thomaston | 15 | 24 | 9 | 10 |
| Waterbury | 284 | 265 | 237 | 226 |
| Watertown | 49 | 51 | 33 | 38 |
| Woodbury | 12 | 13 | 14 | 12 |
| Wolcott | 16 | 18 | 21 | 20 |
| **Total for Service Area** | **486** | **466** | **392** | **378** |
| Other Towns | 53 | 32 | 28 | - |
| **Grand Total** | **539** | **498** | **420** | **-** |

* First ten months of FY. Source: CHIME Inpatient Discharges for patients ages 0 to 18 (excludes newborns).

*(December 13, 2007, Initial CON Submission, page 40)*

12. The following table reports the number of children under age 18, excluding newborns, who were treated at the SMH emergency department ("ED") or the WH ED:

**Table 4: Number of Children Treated in SMH ED and WH ED**

| Facility | Category | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|
| Saint Mary's Hospital | Treated and Discharged | 15,098 | 15,881 | 15,855 |
| | Treated and Admitted | 586 | 554 | 575 |
| | Total | 15,684 | 16,435 | 16,430 |
| Waterbury Hospital | Treated and Discharged | 10,225 | 9,685 | 9,157 |
| | Treated and Admitted | 348 | 384 | 385 |
| | Total | 10,573 | 10,069 | 9,542 |

Source: ChimeData ED Data, FY 2005 to FY 2007

13. The following table reports the bed occupancy of the pediatric units at SMH and WH by bed days:

**Table 5: Bed Occupancy by Hospital and Fiscal Year**

| | SMH | | | WH | | |
|---|---|---|---|---|---|---|
| | Fiscal Year | | | Fiscal Year | | |
| | 2005 | 2006 | 2007* | 2005 | 2006 | 2007* |
| Number of Pediatric Beds | 12 | 12 | 12 | 10 | 10 | 10 |
| Maximum Number of Bed Days per Year | 4,380 | 4,380 | 4,380 | 3,650 | 3,650 | 3,650 |
| Pediatric Discharges | 717 | 690 | 741 | 498 | 420 | 491 |
| Average Length of Stay | 2 | 2 | 2 | 2 | 2 | 2 |
| Number of Pediatric Bed Days | 1,434 | 1,380 | 1,482 | 996 | 840 | 982 |
| Bed Occupancy, %^ | 32.7% | 31.5% | 33.8% | 27.3% | 23.0% | 26.9% |

* Source of FY 2007 pediatric discharges: OHCA Hospital Inpatient Discharge Database.
^ (Pediatric bed days/Maximum number of bed days per year) * 100.
*(January 23, 2008, Completeness Submission, page 2)*

14. The following table reports the number of projected admissions at the proposed CCMC pediatric inpatient unit, and the projected number of total inpatient days:

**Table 6: Projected Volume**

| | FY 2008 * | FY 2009 | FY 2010 |
|---|---|---|---|
| Admissions | 276 | 1,100 | 1,133 |
| Total Inpatient Days | 550 | 2,200 | 2,266 |

*Last quarter of 2008 only.
Note: These calculations are based upon a moving average of total pediatric inpatient admissions at WH and SMH for FY 2005 to FY 2007. CCMC is projecting 3% growth in FY 2010. The projected average length of stay is 2.0 days, the weighted average current length of stay for WH and SMH.
*(December 13, 2007, Initial CON Submission, page 4)*

15. CCMC is proposing a 12-bed unit, based on the following factors:
    - 1,100 pediatric admissions with an average length of stay of 2.0 days;
    - An average daily census for SMH and WH of 6.03 patients;
    - An estimated peak of 10.6 patients and a low 4.5 patients; and
    - Seasonal variations and additional bed flexibility for patients who stay less than 24 hours and are not reported in the daily census.

    *(January 23, 2008, Completeness Submission, pages 1 and 2)*

16. CCMC currently meets the guidelines of the American Academy of Pediatrics Committee on Hospital Care for facilities and equipment and for staffing patterns for patient care and support personnel at its main campus in Hartford. CCMC plans to meet these guidelines at the new satellite unit in Waterbury. *(December 13, 2007, Initial CON Submission, page 4)*

17. The Memorandum of Understanding concerning pediatric care in the Waterbury area has the following provisions:
    - CCMC will create a single community-wide pediatric program;
    - CCMC will own, operate and supervise an inpatient pediatric medical/surgical services unit located on the campus of SMH;
    - CCMC shall contract for space, equipment and support services from SMH as needed;
    - Initial contract is for five years, with automatic five year renewals;
    - Termination of contract requires 12 months notification;
    - SMH and WH Emergency Departments will continue to treat children;
    - SMH and WH will continue to provide children's outpatient services; CCMC will provide clinical leadership and enhanced training opportunities for clinical staff at both SMH and WH; and
    - CCMC shall provide all services and operate its program in accordance with the Ethical and Religious Directives for Catholic Health Care Services.

    *(December 27, 2007, Memorandum of Understanding dated December 19, 2007)*

18. Patients will be admitted to the new pediatric inpatient unit either by their community physician or from transfer from the SMH's ED or WH's ED. *(March 19, 2008, Response to Additional Late File Request, page 2)*

19. For pediatric patients who have received a disposition from WH that an inpatient admission is required, transportation to the admitting hospital will be by ambulance. No transportation will be provided by parents or guardians. *(March 19, 2008, Additional Late File Request Response, page 2)*

20. The attending physician at the referring hospital is responsible for "medical control" until the patient arrives at the receiving hospital. The ambulance company will be the responsible party until care is transferred to the staff of the receiving hospital. *(March 19, 2008, Additional Late File Request Response, page 2)*

21. In FY 2006, WH had 420 pediatric inpatients, of whom 340 (81%) were admitted through its ED. It is estimated that 324 will be the approximate number of patients that may be transported to SMH for admission to the CCMC pediatric inpatient unit. *(March 19, 2008, Additional Late File Request Response, page 3)*

22. The majority of patients at the CCMC pediatric inpatient unit will be admitted by physicians from the Waterbury community who elect to have CCMC privileges. CCMC medical staff will oversee the care provided at the proposed pediatric inpatient unit to assist the physicians of record in day-to-day care of those patients. CCMC medical staff will include a full time medical director and mid-level practitioners, a combination of APRNs and physician assistants who will work under the direct supervision of that physician. Specialists on the CCMC medical staff, members of the CCMC Faculty Practice Plan or other CCMC-associated practices will be available on a consultative basis, at the request of the attending physician. If a patient requires ongoing specialty care they will likely be initially

admitted to CCMC in Hartford or will be transferred to that facility. *(January 23, 2008, Completeness Submission, page 2 and February 20, 2008, Hearing Testimony of Leonard Banco)*

23. The proposal will enhance the ability to recruit and retain pediatric staff through the integration with the staff of a children's hospital. CCMC has infrastructure for the education and training of pediatric healthcare professionals, including nursing and medical professional and post-graduate education programs that will support the consolidated department in Waterbury. This proposal will provide increased opportunities for recruitment of staff with pediatric skills and maintenance of their competency, and will allow pediatric staff to rotate between secondary and tertiary environments of care to enhance clinical education and maintenance of skills. *(December 13, 2007, Initial CON Submission, pages 4, 8, &17 and February 20, 2008, Hearing Testimony of Robert Ritz)*

24. Surgeons are less likely to have privileges at both hospitals, rather admitting to one or the other most of the time. Surgical patients below the age of 18, mostly orthopedic or general surgery patients, comprise a small percentage of patients admitted to the pediatric inpatient units. *(December 13, 2007, Initial CON Submission, page 9)*

25. The following conditions are frequently the reasons for pediatric inpatient admissions to SMH and WH:
    - Appendectomy;
    - Bronchitis, asthma, pneumonia, or pleurisy;
    - Cellulitis;
    - Concussion;
    - Diabetes;
    - Digestive disorders;
    - Kidney and urinary tract infections; and
    - Nutritional and miscellaneous metabolic disorders.

    *Source: OHCA Hospital Inpatient Discharge Database 2005 to 2007.*

26. With respect to CCMC, most referrals from the proposal's service area have been made by community pediatricians or family practitioners to pediatric medical and surgical sub-specialists who then admit them to CCMC. Additionally, a smaller number of admissions have been the result of inter-hospital transfers made by WH and SMH to CCMC. *(December 13, 2007, Initial CON Submission, page 9)*

27. The transfer policy concerning patients that require admission from the WH ED to the CCMC pediatric inpatient unit at SMH or another in-patient facility includes the following provisions:
    - The ED physician at WH will contact the accepting inpatient physician and arrange a bed transfer upon agreement that the patient's condition is appropriate for the level of care;
    - WH ED nursing staff communicate the nursing report to the receiving inpatient nursing staff;
    - Standard transfer documents and copies of patient care documentation and diagnostic studies are sent with the patient or faxed to the inpatient unit;

- Arrangements are made by the WH ED for appropriate levels of ambulance transport services;
- WH ED will serve as medical control during the transfer;
- Patients will be brought directly to the CCMC unit via the SMH ED entrance;
- The patient's caregiver or family will be informed of transfer arrangements and if permissible may accompany patient in the ambulance.

*(March 19, 2008, Additional Late File Request Response, Attachment 3)*

28. Follow-up outpatient care for patients discharged from the CCMC pediatric inpatient unit will be arranged by the patient's attending physician of record or designee. *(January 23, 2008, Completeness Response, page 5)*

29. As part of the transfer and admission process from WH's ED, SMH's ED and private physicians' offices, all patients will be informed about the new CCMC pediatric inpatient unit. The general public will be informed about the unit through a communications plan including press releases, paid advertisements, the public web sites of all three hospitals, and external signage at the hospitals. *(March 19, 2008, Additional Late File Request Response, Attachment 1)*

30. The draft communications plan indicates that press releases and paid advertisements to the general public will communicate that the CCMC pediatric inpatient unit at SMH will provide services in accordance with the Ethical and Religious Directives for Catholic Health Care Services, and that patients who prefer to be treated in a non-denominational environment will be transferred to CCMC in Hartford or another facility as directed by their attending physician. *(March 19, 2008, Additional Late File Request Response, Attachment 1)*

31. CCMC and SMH will have a Master Service Agreement where, on an exclusive basis, all of CCMC's needs for services shall be provided by SMH. SMH will provide the following services to the CCMC pediatric inpatient unit:
    - Perioperative;
    - Imaging;
    - Diagnostic Laboratory;
    - Pharmacy;
    - Pulmonary and Respiratory Therapies;
    - Supplies, any and all without limitation; and
    - Rehabilitative.

    *(March 19, 2008, Late File 1)*

32. The lease between SMH and CCMC has a five year term with two successive renewal options of five years each. The lease includes, but is not limited to, the following services:
    - Maintenance and repair;
    - Security;
    - Laundry and housekeeping;
    - Telecommunications; and
    - Occupational and Social.

    *(March 19, 2008, Late File 1)*

33. The following table summarizes the changes in staffed, licensed, and pediatric inpatient beds for each of the three hospitals:

**Table 7: Summary of Changes to Staffed, Licensed, and Pediatric Patient Beds**

| Hospital | Bed Description | Existing Licensed/ Staffed | Proposed Increase or (Decrease) | Proposed Licensed/ Staffed |
|---|---|---|---|---|
| CCMC | Total | 135/127 | 12 | 147/139 |
| | Pediatric Medical/Surgical | 103/92 | 12 | 115/104 |
| SMH | Total | 347/209 | 3 staffed adult | 347/200 |
| | Pediatric Medical/Surgical | 12 | (12)* | 0/0 |
| WH | Total | 357/246 | 0 | 357/246 |
| | Pediatric Medical/Surgical | 10 | (10)** | 0/0 |

*Existing 12-bed unit will become the new CCMC owned and operated pediatric unit; SMH will add 3 staffed adult medical/surgical beds.
**Existing 10-bed unit will be used for adult medical/surgical beds.
*(December 13, 2007, Initial CON Submission, page 10 and January 23, 2008, Completeness Response, page 3)*

34. Martin Gavin, President, CCMC, testified at the hearing that:
    - The strategic mission of CCMC since its inception in 1996 has been to bring the highest level of pediatric care to as many children as possible;
    - Two years ago local pediatricians approached SMH and WH to consider the consolidation of the two inpatient pediatric units into a single unit;
    - For the past two years leaders from CCMC and the two hospitals have met regularly to investigate the best means to deliver pediatric inpatient care; and
    - For children that come to Hartford and do not have insurance CCMC makes every attempt to enroll them in the HUSKY program.

    *(February 20, 2008, Hearing Testimony of Martin Gavin)*

35. Gerald Boisvert, the Chief Financial Office for CCMC, stated at the hearing, "If necessary, CCMC would absorb the cost of the ambulance ride from WH's ED to SMH to be admitted to the new satellite unit." *(February 20, 2008, Hearing Testimony Gerald Boisvert)*

36. Bob Ritz, President and CEO of SMH testified that:
    - The three organizations have considered how to improve the access and quality of inpatient pediatric services in the greater Waterbury community;
    - The proposal is unique as WH and SMH are looking for ways to consolidate services to eliminate costly overhead duplication to improve each hospital's the long-term financial outlook;
    - The proposal will provide opportunities for professionals to train and obtain clinical experiences; and
    - The proposal is responsive to the State of CT's request to look for ways to collaborate with WH.

    *(February 20, 2008, Hearing Testimony of Bob Ritz)*

37. John Tobin, CEO of WH, stated at the hearing that if the proposal were implemented and then terminated, SMH and WH would resume providing the services, perhaps by continuing the same unit under SMH rather than splitting it out to two units. *(February 20, 2008, Hearing Testimony of John Tobin)*

38. Sandra Roosa, SMH, testified that currently WH has more psychiatric services for children than SMH. SMH does receive children requiring psychiatric services in its ED. It is the hospitals' belief that parents will continue to utilize the ED at the hospital of their choice. *(February 20, 2008, Hearing Testimony of Sandra Roosa)*

39. Leonard Banco, MD, CCMC's consultant for the proposal, testified that:
    - The children currently being admitted to SMH and WH are the secondary level inpatients requiring treatment for conditions such as asthma, dehydration, and minor trauma;
    - Most of the patients requiring care by sub-specialists are no longer admitted to SMH or WH, but are generally cared for by CCMC or by Yale-New Haven Hospital. The referring physician and the admitting physician decide where a child needs to be admitted based on the level of expertise required or the severity of the condition and the care that the patient will need; and
    - The CARES[1] unit at CCMC will consider making the Waterbury area the site of its next location for a CARES model program to address the needs of children with psychiatric needs.

    *(February 20, 2008, Hearing Testimony of Dr. Leonard Banco)*

40. Steven Schneider, MD, testified for WH that Medicaid currently pays for ambulance transportation for patients. *(February 20, 2008, Hearing Testimony of Steven Schneider)*

[1] The CARES (Children and Adolescent Rapid Emergency Services) program is a short-term care unit located within Hartford Hospital's Institute of Living under collaboration with CCMC that provides care for children and adolescents who are in psychiatric crisis with intensive psychiatric assessment, stabilization, and case management in order to link the child to community services.

**Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on the Applicants' Rates and Financial Condition**
**Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services**
**Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines**

41. The total capital expenditure for the proposal, to be financed with CCMC's operating funds, is $600,079. The components of the capital expenditure are given in the following table:

**Table 8: Major Cost Components/Total Capital Expenditure**

| | | |
|---|---|---|
| Medical Equipment (Purchase) | $ | $100,000 |
| Non-Medical Equipment (Purchase)* | | $100,079 |
| Construction/Renovation | | $400,000 |
| **Total Capital Expenditure** | **$** | **$600,079** |

* Includes items such as beds, cribs, carts, appliances, and other patient room furniture and equipment.
*(December 13, 2007, Initial CON Submission, pages 12 and 14)*

42. The renovation costs include the creation of more rooms with single beds, so that parents can room-in. The inpatient area will receive a complete finish renovation. The current floor, wall and ceiling materials at SMH are worn and dated, and require replacement. The proposed renovations will be undertaken primarily to create a pediatric-friendly environment that emulates the appearance of CCMC's main campus in Hartford and bring the facility up to CCMC infection control standards. *(December 13, 2007, Initial CON Submission, page 13)*

43. CCMC has set a target date of June 1, 2008 to obtain State of Connecticut Department of Public Health license and plans to begin operations in July 2008. *(December 13, 2007, Initial CON Submission, page 14)*

44. Financial stability will essentially be unchanged for SMH and WH. Both hospitals will no longer employ dedicated pediatric providers or support staff for their former inpatient pediatric units which will partially offset the loss of revenue. *(December 13, 2007, Initial CON Submission, pages 4 and 19)*

45. CCMC will be billing for the proposed services. CCMC will pay SMH for services provided under the Master Service Agreement. CCMC will add a new cost center, "Waterbury Med/Surg." *(December 13, 2007, Initial CON Submission, pages 10-11 and March 19, 2008, Late File 1)*

46. WH's cost center, "Pediatrics" #9100-00, will be terminated. SMH's cost centers, "Pediatrics" #3040 and "Sacred Heart 4" #3085 will be terminated. *(December 13, 2007, Initial CON Submission, pages 4 and 11)*

47. The incremental revenues, expenses, and gain or loss from operations projected for the next three years for each hospital are reported in the following three tables:

**Table 9a: Projected Incremental Revenues, Expenses, and Gain from Operations for CCMC**

| Category | Account | FY 2008 | FY 2009 | FY 2010 |
|---|---|---|---|---|
| Net Patient Revenue | Non-Government | $ 778,465 | $3,431,772 | $3,894,919 |
| | Medicaid | 678,975 | 2,715,900 | 2,797,377 |
| | **Total Net Patient Revenue** | **1,457,440** | **6,147,672** | **6,692,296** |
| Operating Expenses (variable) | Salaries | 374,969 | 1,499,874 | 1,567,369 |
| | Professional | 125,000 | 500,000 | 522,500 |
| | Supplies and Drugs | 247,665 | 990,659 | 1,015,425 |
| | Bad Debts | 33,866 | 142,851 | 155,506 |
| | Other Oper. Expenses | 3,000 | 412,000 | 412,300 |
| Operating Expenses (fixed) | Depreciation | 30,000 | 60,000 | 60,000 |
| | Interest | 0 | 0 | 0 |
| | Lease | 358,750 | 1,435,000 | 1,435,000 |
| | **Total Operating Expense** | 1,173,249 | 5,040,384 | 5,168,100 |
| | **Gain from Operations** | **$ 284,191** | **$1,107,288** | **$1,524,196** |
| | **FTEs** | **5** | **20** | **20** |
| | **Inpatient Days** | **550** | **2,200** | **2,266** |

* Applicants expect that unmet demand will utilize the new CCMC pediatric inpatient unit and be similar to the growth rate at CCMC-Hartford.

*(March 19, 2008, Late File 3, Exhibit 1)*

**Table 9b: Projected Incremental Revenues, Expenses, and Loss from Operations for SMH**

| Category | Account | FY 2008 | FY 2009 | FY 2010 |
|---|---|---|---|---|
| Net Patient Revenue | Non-Government | $(312,000) | $(1,323,000) | $(1,146,000) |
| | Medicaid | (245,000) | (1,035,000) | (1,467,000) |
| | **Total Net Patient Revenue** | **(557,000)** | **(2,358,000)** | **(2,612,000)** |
| | Other Deductions | (242,000) | (926,000) | (1,036,000) |
| | Other Operating Revenue | 251,390 | 1,065,675 | 1,182,189 |
| | **Revenue from Operations** | **(63,610)** | **(366,325)** | **(393,811)** |
| Operating Expense (variable) | Salaries | (282,670) | (1,198,125) | (1,329,000) |
| | Supplies and Drugs | 43,240 | 183,150 | 203,054 |
| | Other Oper. Expenses | 0 | 0 | 0 |
| Operating Expense (fixed) | Depreciation | 0 | 0 | 0 |
| | Interest Expense | 0 | 0 | 0 |
| | Lease Expense | 0 | 0 | 0 |
| | **Total Operating Expense** | **(239,430)** | **(1,014,975)** | **(1,125,946)** |
| | **Gain from Operations** | **$ 233,640** | **$ 937,477** | **$ 732,135** |
| | **FTEs** | **(4)** | **(16)** | **(16)** |
| | **Inpatient Discharges** | **(163)** | **(650)** | **(700)** |

*(March 19, 2008, Late File 3, Exhibit 1)*

**Table 9c: Projected Incremental Revenues, Expenses, and Gain from Operations for WH**

| Category | Account | FY 2008 | FY 2009 | FY 2010 |
|---|---|---|---|---|
| Net Patient Revenue* | Non-Government | $(122,535) | $ (505,687) | $ (521,231) |
| | Medicaid | (210,723) | (869,018) | (922,839) |
| **Total Net Patient Revenue** | | **(333,258)** | **(1,374,705)** | **(1,444,070)** |
| Operating Expense (variable) | Salaries | (227,813) | (938,588) | (966,745) |
| | Professional | (100,000) | (400,000) | (400,000) |
| | Supplies and Drugs | (25,313) | (104,288) | (107,416) |
| | Other Oper. Expenses | - | - | - |
| Operating Expense (fixed) | Depreciation | - | - | - |
| | Interest | - | - | - |
| | Lease | - | - | - |
| **Total Operating Expense** | | **(353,126)** | **(1,442,876)** | **(1,474,161)** |
| **Gain from Operations** | | **$ 19,867** | **$ 68,170** | **$ 30,091** |
| **FTEs** | | **(3)** | **(10)** | **(10)** |
| **Inpatient Discharges** | | **(57)** | **(226)** | **(226)** |

* Projections do not include the revenues and expenses for the additional 10 adult medical/surgical beds that will be staffed after the CCMC opens the pediatric inpatient unit at SMH; includes $7,000 for Emergency Department Revenues for each payer group in FY 2008 and $28,000 for each payer group in FY 2009 and 2010.

*(March 19, 2008, Late File 3, Exhibit 1)*

48. CCMC's projected payer mix for the current year and for the three projected years of the proposal, based on gross patient revenue, are reported in the following table:

**Table 10: CCMC's Payer Mix**

| Payer | Payer Mix | | | |
|---|---|---|---|---|
| | FY 2007 Current | FY2008 Projected | FY 2009 Projected | FY 2010 Projected |
| Medicare | 0.2% | 0% | 0% | 0% |
| Medicaid* (includes other medical assistance and managed care) | 41.4% | 50% | 50% | 50% |
| CHAMPUS and TriCare | 1.0% | 0% | 0% | 0% |
| Commercial Insurers | 55.8% | 49% | 49% | 49% |
| Uninsured | 1.6% | 1% | 1% | 1% |
| **Total Payer Mix** | **100%** | **100%** | **100%** | **100%** |

* Includes managed care activity

*(December 13, 2007, Initial CON Submission, pages 16 and 21-22)*

49. The payer mixes for SMH and WH for the current year and for the total facility for the next three projected years are reported in the following tables:

**Table 11a: SMH's Payer Mix**

| Payer | Payer Mix** | | | |
|---|---|---|---|---|
| | **FY 2007 Current** | **FY2008 Projected** | **FY 2009 Projected** | **FY 2010 Projected** |
| Medicare* | 44.7% | 45.0% | 45.0% | 45.0% |
| Medicaid* (includes other medical assistance) | 14.2% | 14.0% | 14.0% | 14.0% |
| CHAMPUS and TriCare | 0.4% | 0.4% | 0.4% | 0.4% |
| Commercial Insurers* | 37.2% | 37.0% | 37.0% | 37.0% |
| Uninsured | 0.3% | 0.3% | 0.3% | 0.3% |
| Workers Compensation | 3.2% | 3.3% | 3.3% | 3.3% |
| **Total Payer Mix** | **100%** | **100%** | **100%** | **100%** |

* Includes managed care activity.

** Based on Net Patient Revenue for the total facility due to the loss of gross revenue with the termination of pediatric inpatient services.

*(December 13, 2007, Initial CON Submission, page 17)*

**Table 11b: WH's Payer Mix**

| Payer | Payer Mix** | | | |
|---|---|---|---|---|
| | **FY 2007 Current** | **FY2008 Projected** | **FY 2009 Projected** | **FY 2010 Projected** |
| Medicare* | 43.0% | 43.0% | 43.0% | 43.0% |
| Medicaid* (includes other medical assistance) | 11.0% | 11.0% | 11.0% | 11.0% |
| CHAMPUS and TriCare | 0.0% | 0.0% | 0.0% | 0.0% |
| Commercial Insurers* | 41.0% | 41.0% | 41.0% | 41.0% |
| Uninsured | 1.0% | 1.0% | 1.0% | 1.0% |
| Workers Compensation | 4.0% | 4.0% | 4.0% | 4.0% |
| **Total Payer Mix** | **100%** | **100%** | **100%** | **100%** |

* Includes managed care activity.

** Based on Net Patient Revenue for the total facility due to the loss of gross revenue with the termination of pediatric inpatient services.

*(December 13, 2007, Initial CON Submission, page 16)*

50. The following table reports the payer mix for the pediatric patients discharged from SMH and WH in 2007:

**Table 12: Hospital Payer Mix for Pediatric Discharges in 2007**

| Payer | SMH | WH |
|---|---|---|
| Medicare | 0% | 0% |
| Medicaid | 58.0% | 46.5% |
| CHAMPUS and TriCare | 0.3% | 0.2% |
| Commercial Insurers | 38.2% | 50.0% |
| Self Pay | 1.0% | 3.3% |
| Other | 2.5% | 0% |
| **Total Pediatric Discharges Payer Mix** | **100%** | **100%** |

*Source: OHCA Hospital Inpatient Discharge Database 2007.*

51. The proposal's rate for a semi-private room is $2,600. The average pediatric inpatient per diem reimbursement rates for each hospital are reported in the following table:

**Table 13: Average Per Diem Rates for Pediatric Inpatient Services**

| Hospital | Average Per Diem Rates for Pediatric Inpatient Services | |
|---|---|---|
| | ***Government**** ***(Medicare, Medicaid)*** | ***Non-government*** ***(Commercial, Self-pay, and Others)*** |
| CCMC | $2,137 | $2,963 |
| SMH | $850 | $1,725 |
| WH | $820 | $1,680 |

*(December 13, 2007, Initial CON Submission, page 18 and January 23, 2008, Completeness Response, page 7)*

52. There is no State Health Plan in existence at this time. *(December 10, 2007, Initial CON Submission, page 2)*

53. CCMC, SMH, and WH have adduced evidence that the proposal is consistent with their long-range plans. *(December 10, 2007, Initial CON Submission, page 2)*

54. CCMC, SMH, and WH have improved productivity and contained costs through energy conservation, the application of technology, group purchasing, and reengineering. SMH also implemented product standardization and pharmacy standardization, utilization and inventory control. *(December 10, 2007, Initial CON Submission, page 7)*

55. CCMC, SMH, and WH have no teaching or research responsibilities that would change as a result of the proposal. *(December 10, 2007, Initial CON Submission, page 8)*

56. CCMC's unique characteristic of its patient/physician mix is that it is the only freestanding hospital in the state devoted solely to the care of children. It has a full array of pediatric medical and surgical specialists, as well as nursing and ancillary support totally dedicated to the care of children. In addition, it has its own nursing and medical professional and post-graduate education programs that will support the new satellite unit. *(December 10, Initial CON Submission, page 8)*

57. CCMC has sufficient technical and managerial competence and expertise to provide efficient and adequate service to the public. *(December 10, 2007, Initial CON Submission, Attachment 4)*

58. CCMC's rates are sufficient to cover the proposed capital cost and operating costs. *(December 10, 2007, Initial CON Submission, page 13)*

# Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Connecticut Children's Medical Center ("CCMC") is a freestanding children's hospital located at 282 Washington Street in Hartford. Saint Mary's Hospital ("SMH") is a general hospital located at 56 Franklin Street, Waterbury. Waterbury Hospital ("WH") is a general hospital located at 64 Robbins Street, Waterbury. The three hospitals (together, referred to as "Applicants") have presented a plan to collaborate and design a more efficient delivery system for the care of inpatient pediatric patients in the Waterbury area. Although this proposal includes the termination of pediatric inpatient services by WH and SMH, it proposes a 12-bed inpatient pediatric unit that will be located at the SMH facility but owned and operated by CCMC.

The CCMC satellite located at SMH will emulate the look and feel of CCMC's main campus in Hartford. Patients will be admitted to the unit through the emergency departments ("ED") at SMH and WH, or by community physicians from the Waterbury area who elect to have CCMC privileges. A full time medical director and midlevel practitioners will oversee the day-to-day clinical care of patients on with unit, with CCMC physician specialists available for consultation as needed. The attending physician will coordinate follow-up outpatient care for patients discharged from the CCMC inpatient pediatric unit. In the event that a patient requires ongoing specialty care, they will most likely be admitted or transferred to CCMC's main campus in Hartford.

This proposal is the first collaborative venture of this type between CCMC and other providers. The proposal addresses the apparent excess capacity that exists at both SMH and WH while at the same time strengthening the clinical programs and staff competencies through the proposed consolidation of services. SMH currently has 12 pediatric beds, and WH currently has 10 pediatric beds. The pediatric inpatient units at both hospitals have been at approximately 50% capacity during the three most recent fiscal years. The hospitals have a combined average daily census of 6 patients, with a peak of 11 beds and a low of 5 beds. Since it appears that there is excess capacity at both inpatient pediatric units, this proposal's reduction in combined beds from 22 to 12 appears to be reasonable.

OHCA is concerned about access to critical pediatric inpatient services during implementation of the proposal, particularly the transition period between the closing of WH inpatient pediatric unit and the opening of the CCMC inpatient pediatric unit. OHCA is also concerned about the transportation of patients from the WH ED to the CCMC pediatric inpatient unit. Currently WH admits approximately 400 pediatric patients via the ED annually, and it would be this volume of patients that may potentially need

ambulance transport to the CCMC pediatric inpatient unit. OHCA is concerned that additional charges may be incurred by families initially presenting at WH and requiring transfer to CCMC. OHCA questions the impact of these charges and of the ambulance transfer itself on patient satisfaction with the proposed service. Since the unit will be located at SMH, OHCA does not have the same concern with the ED patients at SMH, as they need only be admitted to the CCMC unit on the premises. OHCA is concerned, however, that the proposal may ultimately result in an influx of pediatric volume over time arriving at SMH ED, adding to an already "crowded" ED.

The total capital expenditure for the proposal, to be financed with CCMC's operating funds, is $600,079. CCMC projects incremental gains from operations with the proposal of $192,894, $742,112, and $1,148,073 in fiscal years 2008, 2009, and 2011 respectively. SMH projects incremental gains from operations with the proposal of $233,640, $937,477, and $1,148,073 in fiscal years 2008, 2009, and 2011 respectively. WH projects incremental gains from operations with the proposal of $26,373, $96,654, and $61,034 in fiscal years 2008, 2009, and 2011 respectively. WH's projections do not include any gains/losses from the conversion of 10 pediatric medical/surgical beds to 10 adult medical/surgical beds.

In conclusion, this proposal will improve the quality of and access to specialized pediatric services in the proposed service area through collaboration between hospitals. However OHCA requires that the Applicants address more fully the effects of the proposal and address potential issues related to access, transfer, the admitting process, and other related matters. This approach assures the public of a sound professional facility that will serve the needs of pediatric patients and their families in the greater Waterbury area.

# Order

**NOW, THEREFORE,** the Office of Health Care Access ("OHCA") and Connecticut Children's Medical Center ("CCMC"), Saint Mary's Hospital ("SMH"), and Waterbury Hospital ("WH") (together referred to as "Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request to terminate pediatric inpatient services at SMH and WH and for CCMC to establish, own, and operate pediatric inpatient services at SMH as a satellite facility of CCMC, at an estimated total capital expenditure of $600,079.

1. The Applicants' request for a Certificate of Need regarding the proposal to terminate pediatric inpatient services at SMH and WH and for CCMC to establish, own, and operate inpatient pediatric services at SMH as a satellite facility of CCMC, at an estimated total capital expenditure of $600,079, is hereby approved.

2. CCMC is authorized by OHCA to increase its licensed bed capacity, from 135 licensed beds to 147 licensed beds, an addition of 12 beds. CCMC must also obtain authorization from the State of Connecticut Department of Public Health to increase its licensed bed capacity by 12 beds. These 12 beds can only be staffed and utilized at the new satellite location at SMH and cannot be staffed at any other facility unless CCMC files with OHCA appropriate documentation and receives OHCA approval.

3. SMH, approved to terminate its pediatric inpatient services, must continue to provide such services until CCMC pediatric inpatient unit is licensed and in operation. Failure to remain open until this time may be considered as not filing required information and may subject SMH to civil penalties pursuant to Section 19a-653, C.G.S.

4. WH, approved to terminate its pediatric inpatient services, must continue to provide such services until CCMC is licensed and in operation. Failure to remain open until this time may be considered as not filing required information and may subject WH to civil penalties pursuant to Section 19a-653, C.G.S.

5. There is no authorized change in the number of licensed beds at SMH or WH.

6. No less than two weeks prior to start of operations, CCMC shall file with OHCA written notification of the date upon which CCMC will begin operation of the inpatient pediatric unit within SMH. OHCA must receive this notification and acknowledge receipt of such in writing, prior to SMH and WH terminating their inpatient pediatric services. In addition, CCMC is required to file a copy of its license obtained from the State of Connecticut Department of Public Health to operate the satellite inpatient pediatric services unit.

7. The Applicants will create a charitable pool fund to cover any out-of-pocket expenses that the patient's and/or the parent's or legal guardian's health insurer does not cover as related to the transportation from WH ED to the CCMC satellite unit at SMH. It is the Applicants' responsibility to ensure that the patient's parent or legal guardian is aware of this policy. CCMC will administer the charitable pool fund and provide OHCA with the appropriate documentation of its formation. CCMC will report the usage of such funds to OHCA at meetings as stipulated in Condition 15.

8. Patients transported from WH ED to CCMC pediatric inpatient unit shall be directly admitted to the pediatric inpatient unit and shall not be admitted to the SMH Emergency Department ("ED"). In the event this occurs, SMH must cover all expenses related to this second ED visit.

9. SMH and WH will continue to provide outpatient and ED services to children.

10. Should SMH and/or WH propose to recommence pediatric inpatient services, each hospital shall file with OHCA appropriate documentation, including either a Certificate of Need Determination Request or a Certificate of Need Letter of Intent.

11. Should the agreement among the Applicants established by the Memorandum of Understanding be terminated, CCMC must obtain CON authorization from OHCA before termination of its pediatric inpatient unit at SMH.

12. CCMC will work to ensure that all community pediatricians/family practitioners and surgeons who have provided care for children at either or both SMH and WH will elect to have active privileges at CCMC in order to admit patients to the pediatric inpatient unit. CCMC will also reach out to additional practitioners in the Waterbury area in an effort to include all potential pediatric providers.

13. It is the responsibility of CCMC to inform the public of the new pediatric inpatient unit at SMH and that its services will be provided in accordance with the Ethical and Religious Directives for Catholic Health Care Services ("ERD").

14. CCMC shall distribute a Patient Satisfaction Survey to each patient, parent, or legal guardian that has been provided services at the pediatric inpatient unit. The survey shall be able to segment patients originating from WH and SMH EDs and shall have questions that focus on topics that include, but are not limited to:
    - Transfer and transport issues;
    - Prior knowledge of CCMC being the hospital provider;
    - Knowledge of the staff regarding the new satellite unit;
    - Knowledge of the ERD;
    - Overall patient experience, quality; and
    - Any other relevant feedback.

    The results of this survey are most important at the inception of the program and will be required for only the first full twelve months of operations. OHCA requires

that CCMC provide quarterly aggregated results one month after the completion of a calendar quarter.

15. OHCA requires meetings between the Applicants and OHCA concerning the operation of the CCMC pediatric inpatient unit. The first meeting with OHCA shall occur approximately two weeks prior to commencement of the operations of the pediatric inpatient unit. It will be at the discretion of OHCA to determine the frequency and number of future meetings to be held and the information that must be submitted at each meeting. Unless otherwise notified in writing by OHCA the meetings will focus on operational issues or barriers of access to care, including, but not limited to, transfer, admitting process, and ED issues.

16. CCMC must post a toll-free telephone number for patients, parents or legal guardians to call if they have concerns or complaints concerning CCMC pediatric inpatients services at SMH.

17. The Applicants shall provide OHCA with a finalized copy of the Master Service Agreement and each schedule, exhibit, attachment, and addendum to the Agreement within 30 days of execution of the Master Service Agreement.

18. The authorization shall expire on April 30, 2010. Should the termination of existing pediatric inpatient services at SMH and WH and establishment of new satellite pediatric inpatient services with CCMC as the license holder and operator not be completed by that date and available to patients, the Applicants must seek further approval from OHCA to complete the project beyond that date.

19. The Applicants shall not exceed the approved capital expenditure of $600,079. In the event that the Applicants learn of potential cost increases or expect that the final project costs will exceed those approved, the Applicants shall file with OHCA a request for approval of the revised project budget.

20. OHCA and CCMC, SMH, and WH agree that this Agreed Settlement represents a final agreement between OHCA and CCMC, SMH, and WH with respect to this request. The signing of this Agreed Settement resolves all objections, claims and disputes, which may have been raised by the Applicants with regard to Docket Number: 07-31003-CON.

21. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

***Signed by Martin J. Gavin on April 30, 2008***

_____
Date

_____
Duly Authorized Agent for
Connecticut Children's Medical Center

***Signed by Michael Novak on April 30, 2008***

_____
Date

_____
Duly Authorized Agent for
Saint Mary's Hospital

***Signed by Colleen Scott on May 1, 2008***

_____
Date

_____
Duly Authorized Agent for
Waterbury Hospital

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on May 1, 2008.

***Signed by Commissioner Vogel on May 1, 2008***

| | |
|---|---|
| Date | Cristine A. Vogel<br>Commissioner |

# EXHIBIT 28

Execution Copy

# TRANSFER AGREEMENT

**by and among**

**SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION**

**and**

**SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.**

**Dated as of September 18, 2015**

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## TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties**."

## RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

**NOW, THEREFORE**, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

## ARTICLE I
## DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

**"Amended and Restated Certificates of Incorporation of SMHS and SMH"** means the amended and restated certificates of incorporation contemplated by **Section 2.01.**

**"Amended and Restated Bylaws of SMH"** means the amended and restated bylaws contemplated by **Section 2.01.**

**"Applicable Exceptions"** means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

**"Balance Sheet"** has the meaning set forth in **Section 6.06.**

**"Balance Sheet Date"** has the meaning set forth in **Section 6.06.**

**"Capital Expenditures"** means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02.**

**"CERCLA"** means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

**"Certification of AFFAP"** has the meaning set forth in **Section 6.22(c).**

**"Church Plan"** has the meaning set forth in **Section 6.22(e).**

**"Closing"** has the meaning set forth in **Section 5.01.**

**"Closing Date"** has the meaning set forth in **Section 5.01.**

**"COBRA"** means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

**"Code"** means the Internal Revenue Code of 1986, as amended.

**"Committed Capital"** has the meaning set forth in **Section 4.01.**

**"Confidentiality Agreement"** means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

**"Confidential Information"** has the meaning set forth in **Section 8.11(a).**

**"Contracts"** means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

**"CONs"** has the meaning set forth in **Section 8.04.**

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth in **Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**NE-RHM**" has the meaning set forth in the preamble.

"**NE-RHM Controlled Subsidiary**" means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

"**NE-RHM Providers**" means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

**"Permits"** means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

**"Permitted Encumbrances"** has the meaning set forth in **Section 6.10(b)**.

**"Person"** means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

**"Prohibited Transaction"** is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

**"Potential Investment Opportunity"** has the meaning set forth in **Section 4.05**.

**"Real Property"** means, collectively, the Owned Real Property and the Leased Real Property.

**"Recipient"** has the meaning set forth in **Section 8.11(a)**.

**"Regional Health Ministry"** or **"RHM"** has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

**"Release"** means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

**"Representative"** means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

**"Review Period"** has the meaning set forth in **Section 8.08(b)**.

**"Saint Francis/Trinity Transfer Date"** has the meaning set forth in the Recitals.

**"Saint Mary's"** has the meaning set forth in the preamble.

**"Saint Mary's Assets"** means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

**"Saint Mary's Benefit Plan"** has the meaning set forth in **Section 6.22(a)**.

**"Saint Mary's Controlled Subsidiary"** means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

**"Saint Mary's Employees"** has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

"**Trinity Health Controlled Subsidiary**" means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

**"Withdrawal Liability"** has the meaning set forth in **Section 6.22(d)**.

## ARTICLE II
## TRANSFER

**Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH.** As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

**Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy.** In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

## ARTICLE III
## GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

**Section 3.01 Governance.** As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

**Section 3.02 NE-RHM Board of Directors.** As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

**Section 3.03 Other Appointments.** A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

**Section 3.04 President and CEO of Saint Mary's.** Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

**Section 3.05 Name and Branding.** Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

**Section 3.06 Catholic Identity.** Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

**Section 3.07 Operational Commitments.** For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

**Section 3.08 Medical Staff.** Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

**Section 3.09 Community Benefit.**

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

**Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.**

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

**Section 3.11 Debt and Long-Term Liabilities.**

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

## ARTICLE IV
## CAPITAL COMMITMENT

**Section 4.01 Capital Commitment.** During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

**Section 4.02 Use of the Committed Capital.** The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

**Section 4.03 Obligation to Repay Loans.** Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

**Section 4.04 Additional Capital Needs.** The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

## ARTICLE V
## CLOSING

**Section 5.01 Closing.** Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

**Section 5.02 Closing Deliverables.**

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

## ARTICLE VI
### REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

**Section 6.01 Organization and Corporate Authority.**

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

**Section 6.02 Tax-Exempt Status.** Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

**Section 6.03 Authorization and Enforceability of this Agreement.** The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

**Section 6.04 No Conflicts; Consents.** The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

**Section 6.05 Saint Mary's Subsidiaries.** The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

**Section 6.06 Financial Statements.** Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date**."

**Section 6.07 Undisclosed Liabilities.** Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

**Section 6.08 Absence of Certain Changes, Events and Conditions.** Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

cont do: a, b, c, o, q
consent for: d, e h, i, k, m, m, p
notify: f, g, j, l

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

**Section 6.09 Material Contracts.**

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c)**, and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

**Section 6.10 Title to Saint Mary's Assets.**

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, **"Permitted Encumbrances"** means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

**Section 6.11 Condition and Sufficiency of the Saint Mary's Assets.** Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

**Section 6.12 Real Property.**

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

**Section 6.13 Intangible Personal Property; Software.**

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

**Section 6.14 Legal Proceedings; Governmental Orders.**

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

**Section 6.15 Compliance with Laws; Permits.**

(a) Except as set forth in **Schedule 6.15(a)** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

**Section 6.16 Medicare Participation/Accreditation**

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

**Section 6.17 Compliance Programs**

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

**Section 6.18 Corporate Integrity Agreements.** Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

**Section 6.19 HIPAA.** To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

**Section 6.20 Affiliate Transactions.** Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary ("**Interested Person**") directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

**Section 6.21 Environmental Matters.**

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

**Section 6.22 Employee Benefit Matters.**

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

**Section 6.23 Employment Matters.**

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

**Section 6.24 Taxes.**

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

**Section 6.25 Insurance. Schedule 6.25** of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the **"Saint Mary's Insurance Policies"**); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

**Section 6.26 Medical Staff.** SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

**Section 6.27 Brokers.** Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

**Section 6.28 Due Diligence.** Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

**Section 6.29 Full Disclosure.** No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

**Section 6.30 No Other Representations and Warranties.** Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

## ARTICLE VII
## REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

**Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.**

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

**Section 7.02 Tax-Exempt Status.** Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

**Section 7.03 Authorization and Enforceability of this Agreement.** The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

**Section 7.04 No Conflicts; Consents.** The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

**Section 7.05 Brokers.** Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

**Section 7.06 Legal Proceedings.** There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

**Section 7.07 Financial Statements.**

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

**Section 7.08 Compliance with Laws; Permits.**

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

**Section 7.09 Medicare Participation/Accreditation**

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

**Section 7.10 Compliance Programs**

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

**Section 7.11 Corporate Integrity Agreements.** Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

**Section 7.12 HIPAA.** To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12.**

**Section 7.13 Financial Capacity.** NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

**Section 7.14 Due Diligence.** NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

**Section 7.15 Full Disclosure.** No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

**Section 7.16 No Other Representations and Warranties.** Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

## ARTICLE VIII
## COVENANTS

**Section 8.01 Conduct of Operations Prior to the Effective Date.**

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

**Section 8.02 Regional Strategy/Structure and Integration Plan.** As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

**Section 8.03 Access to Information.**

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

**Section 8.04 Efforts to Consummate.** Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need (**"CONs"**), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access (**"OHCA"**) for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

**Section 8.05 Updated Financial Statements.** Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06**. The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

**Section 8.06 Employment Matters.**

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

**Section 8.07 Insurance.**

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

**Section 8.08 Title and Survey Matters.**

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

**Section 8.09 Transfer Taxes.** All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

**Section 8.10 Public Announcements.** Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

**Section 8.11 Confidentiality.**

(a) **"Confidential Information"** means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a **"Disclosing Party"**) or its Representatives to the other Party (a **"Recipient"**) and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term **"Confidential Information"** does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

**Section 8.12 Updated Disclosure Schedules.** Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

**Section 8.13 Further Assurances.** Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

**Section 8.14 No Shop.** The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

## ARTICLE IX
## CONDITIONS TO CLOSING

**Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health.** The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02;**

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or 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 Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

**Section 9.02 Conditions Precedent to Obligations of Saint Mary's.** The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or 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 NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

## ARTICLE X
## TERMINATION

**Section 10.01 Termination.** This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

**Section 10.02 Effect of Termination.** In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X, Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

## ARTICLE XI
### MISCELLANEOUS

**Section 11.01 Survival.** None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

**Section 11.02 Expenses.** Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

**Section 11.03 Notices.** All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

<u>If to Saint Mary's</u>
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

<u>With a copy to:</u>
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

**Section 11.04 Interpretation.** For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

**Section 11.05 Headings.** The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

**Section 11.06 Severability.** If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

**Section 11.07 Entire Agreement.** This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

**Section 11.08 Successors and Assigns.** This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

**Section 11.09 No Third Party Beneficiaries.** This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

**Section 11.10 Amendment and Modification; Waiver.** This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

**Section 11.11 Governing Law; Submission to Jurisdiction.** This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

**Section 11.12** **Specific Performance.** The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

**Section 11.13** **Counterparts.** This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

**SIGNATURE PAGE FOLLOWS**

**IN WITNESS WHEREOF,** and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

**SAINT MARY'S HEALTH SYSTEM, INC.**

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

**TRINITY HEALTH CORPORATION**

By: _____

Name: James R. O'Connell

Title: Executive Vice President

**SAINT FRANCIS CARE, INC.**

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

# EXHIBIT 29

*Waterbury Republican*
*October 27, 2015*

# Borough 'gateway' unveiled

## Developer shares pictures of project plans for Parcel C

BY PAUL SINGLEY
REPUBLICAN-AMERICAN

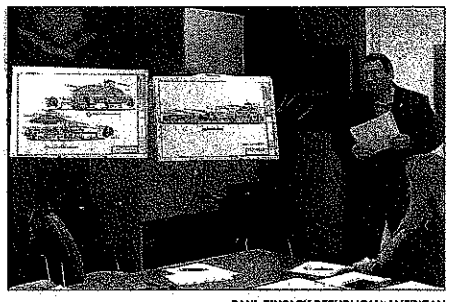
NAUGATUCK — Borough officials were enthusiastic Monday when developer Rob Oris unveiled pictures of his much anticipated project on Parcel C downtown.

Oris, a veteran developer and Naugatuck native, showed architectural renderings for his proposal, which calls for a three-story, 30,000-square-foot medical office complex and a 5,000-square-foot retail/restaurant facility on the corner of Maple and Water streets.

"Our goal was to create a gateway to Naugatuck that we can all be really proud of," he said. "It's going to kick-start downtown revitalization."

Oris presented to the Naugatuck Economic Development Corp. and the Board of Mayor and Burgesses during separate meetings Monday night. Both boards unanimously approved the project. It will now go through the land use process. If approved, construction would begin in the spring.

The medical complex, which Oris believes will be a draw for people downtown, will be anchored by Saint Mary's Hospital of Waterbury. The first two floors will each be 11,000 square feet, while the third floor will be about 7,500 square feet, Oris said.



PAUL SINGLEY REPUBLICAN-AMERICAN

**Developer Rob Oris shows renderings of his proposal for Parcel C in Naugatuck to borough officials Monday night.**

*See* **PARCEL**, *Page* **4B**

# PARCEL: Partners seek 'higher end' tenants

The buildings will face Maple Street and parking will be in the back. The renderings show a stucco material for the siding that is a mix of maroon and beige colors on the facade, a physical therapy fitness facility on the top floor and an outdoor seating area on the top floor.

There will be a courtyard in the front of the development with flower beds and a large flagpole. People will primarily enter the building from the back, where the parking lot is located.

Oris said the goal was to make the buildings look similar to the more appealing buildings in Naugatuck's downtown.

He said he is speaking with "an upscale coffee shop" to be a tenant in the smaller building, but stopped short of saying it is Starbucks.

PAUL SINGLEY REPUBLICAN-AMERICAN

**These are renderings of a developer's plans for Parcel C in downtown Naugatuck. The plans call for a medical office complex and a second building that will have both an 'upscale coffee maker' and a bank, both with drive-thru windows. Naugatuck officials approved the plans Monday night.**

The other tenant in the smaller building will be a bank. Both will have drive-thru windows.

Oris' partner, veteran developer John Lombard, said he thinks the traditional phrase of "if you build it, they will come" is not exactly what the developers were going for with this project.

"What's more important is who will come," Lombard said. "We're not out to attract a low-end tenant. We're trying to attract higher-end tenants.

"If we have that draw, what happens across the street (with future developments) is also going to feed off this," he said. "We're looking to bring in the best tenants, who are paying the most money and are successful over the long term."

*Contact Paul Singley at psingley@rep-am.com, on Facebook at RA Naugatuck or on Twitter @RANaugatuck.*

# EXHIBIT 30

Saint Mary's Hospital (only)
Financial Worksheet (A)

NON-PROFIT

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| LINE | Total Entity: Description | (1) FY 2015 Actual Results | (2) FY 2016 Projected W/out CON | (3) FY 2016 Projected Incremental | (4) FY 2016 Projected With CON | (5) FY 2017 Projected W/out CON | (6) FY 2017 Projected Incremental | (7) FY 2017 Projected With CON | (8) FY 2018 Projected W/out CON | (9) FY 2018 Projected Incremental | (10) FY 2018 Projected With CON | (11) FY 2019 Projected W/out CON | (12) FY 2019 Projected Incremental | (13) FY 2019 Projected With CON |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A. | OPERATING REVENUE | | | | | | | | | | | | | |
| 1 | Total Gross Patient Revenue | $746,752 | $786,099 | | $786,099 | $825,404 | | $825,404 | $866,674 | | $866,674 | $910,008 | | $910,008 |
| 2 | Less: Allowances | $484,798 | $513,815 | | $513,815 | $545,158 | | $545,158 | $578,412 | | $578,412 | $613,695 | | $613,695 |
| 3 | Less: Charity Care | $1,854 | $1,947 | | $1,947 | $2,044 | | $2,044 | $2,146 | | $2,146 | $2,254 | | $2,254 |
| 4 | Less: Other Deductions | $4,232 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 |
| | Net Patient Service Revenue | $255,868 | $260,591 | $0 | $260,591 | $268,456 | $0 | $268,456 | $276,370 | $0 | $276,370 | $284,313 | $0 | $284,313 |
| 5 | Medicare | $98,309 | $100,067 | | $100,067 | $103,087 | | $103,087 | $106,126 | | $106,126 | $109,176 | | $109,176 |
| 6 | Medicaid | $47,555 | $45,864 | | $45,864 | $47,248 | | $47,248 | $48,641 | | $48,641 | $50,039 | | $50,039 |
| 7 | CHAMPUS & TriCare | $199 | $1,824 | | $1,824 | $1,879 | | $1,879 | $221 | | $221 | $227 | | $227 |
| 8 | Other | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | Total Government | $146,062 | $147,755 | $0 | $147,755 | $152,215 | $0 | $152,215 | $154,988 | $0 | $154,988 | $159,443 | $0 | $159,443 |
| 9 | Commercial Insurers | $92,482 | $95,376 | | $95,376 | $98,255 | | $98,255 | $101,151 | | $101,151 | $104,058 | | $104,058 |
| 10 | Uninsured | $8,522 | $8,600 | | $8,600 | $8,859 | | $8,859 | $9,120 | | $9,120 | $9,382 | | $9,382 |
| 11 | Self Pay | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 12 | Workers Compensation | $7,785 | $7,818 | | $7,818 | $8,054 | | $8,054 | $8,291 | | $8,291 | $8,529 | | $8,529 |
| 13 | Other | $1,017 | $1,042 | | $1,042 | $1,074 | | $1,074 | $1,105 | | $1,105 | $1,137 | | $1,137 |
| | Total Non-Government | $109,806 | $112,836 | $0 | $112,836 | $116,242 | $0 | $116,242 | $119,668 | $0 | $119,668 | $123,107 | $0 | $123,107 |
| | Net Patient Service Revenue (Government+Non-Government) | $255,868 | $260,591 | $0 | $260,591 | $268,456 | $0 | $268,456 | $274,656 | $0 | $274,656 | $282,550 | $0 | $282,550 |
| 14 | Less: Provision for Bad Debts | $8,180 | $8,512 | | $8,512 | $8,938 | | $8,938 | $9,384 | | $9,384 | $9,854 | | $9,854 |
| | Net Patient Service Revenue less provision for bad debts | $247,688 | $252,079 | $0 | $252,079 | $259,519 | $0 | $259,519 | $266,985 | $0 | $266,985 | $274,459 | $0 | $274,459 |
| 15 | Other Operating Revenue | $7,473 | $6,267 | | $6,267 | $6,267 | | $6,267 | $6,267 | | $6,267 | $6,267 | | $6,267 |
| 17 | Net Assets Released from Restrictions | $733 | $700 | | $700 | $700 | | $700 | $700 | | $700 | $700 | | $700 |
| | TOTAL OPERATING REVENUE | $255,894 | $259,046 | $0 | $259,046 | $266,486 | $0 | $266,486 | $273,952 | $0 | $273,952 | $281,426 | $0 | $281,426 |
| B. | OPERATING EXPENSES | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $88,793 | $93,086 | | $93,086 | $95,413 | | $95,413 | $97,798 | | $97,798 | $100,243 | | $100,243 |
| 2 | Fringe Benefits | $27,562 | $25,721 | | $25,721 | $26,364 | | $26,364 | $27,023 | | $27,023 | $27,699 | | $27,699 |
| 3 | Physicians Fees | $10,621 | $11,268 | | $11,268 | $11,606 | | $11,606 | $11,954 | | $11,954 | $12,313 | | $12,313 |
| 4 | Supplies and Drugs | $45,059 | $44,320 | | $44,320 | $46,536 | ($652) | $45,884 | $48,863 | ($1,368) | $47,495 | $51,306 | ($1,437) | $49,869 |
| 5 | Depreciation and Amortization | $10,805 | $11,116 | | $11,116 | $11,449 | | $11,449 | $11,793 | | $11,793 | $12,147 | | $12,147 |
| 6 | Provision for Bad Debts-Other[b] | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | Interest Expense | $963 | $216 | | $216 | $205 | | $205 | $195 | | $195 | $185 | | $185 |
| 8 | Malpractice Insurance Cost | $5,350 | $5,094 | | $5,094 | $5,196 | | $5,196 | $5,300 | | $5,300 | $5,406 | | $5,406 |
| 9 | Lease Expense | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Other Operating Expenses | $49,045 | $48,175 | | $48,175 | $49,139 | ($708) | $48,431 | $50,121 | ($1,403) | $48,718 | $51,124 | ($1,431) | $49,692 |
| | TOTAL OPERATING EXPENSES | $238,198 | $238,996 | $0 | $238,996 | $245,908 | ($1,359) | $244,549 | $253,048 | ($2,772) | $250,276 | $260,422 | ($2,868) | $257,554 |
| | INCOME/(LOSS) FROM OPERATIONS | $17,696 | $20,050 | $0 | $20,050 | $20,577 | $1,359 | $21,936 | $20,904 | $2,772 | $23,676 | $21,004 | $2,868 | $23,872 |
| | NON-OPERATING REVENUE | $3,158 | $3,716 | | $3,716 | $3,827 | | $3,827 | $3,942 | | $3,942 | $4,061 | | $4,061 |

Saint Mary's Hospital (only)
Financial Worksheet (A)

NON-PROFIT

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| LINE | Total Entity: | (1) FY 2015 Actual | (2) FY 2016 Projected | (3) FY 2016 Projected | (4) FY 2016 Projected | (5) FY 2017 Projected | (6) FY 2017 Projected | (7) FY 2017 Projected | (8) FY 2018 Projected | (9) FY 2018 Projected | (10) FY 2018 Projected | (11) FY 2019 Projected | (12) FY 2019 Projected | (13) FY 2019 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 |
| | EXCESS/DEFICIENCY OF REVENUE OVER EXPENSES | $20,854 | $23,766 | $0 | $23,766 | $21,405 | $1,359 | $22,764 | $24,347 | $2,272 | $26,619 | $25,041 | $2,888 | $27,932 |
| | Principal Payments | $3,000 | $3,000 | | $3,000 | $3,000 | | $3,000 | $3,000 | | $3,000 | $3,000 | | $3,000 |
| C. | PROFITABILITY SUMMARY | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | 6.8% | 7.6% | 0.0% | 7.6% | 7.5% | 0.0% | 8.1% | 7.5% | 0.0% | 8.5% | 7.4% | 0.0% | 8.4% |
| 2 | Hospital Non Operating Margin | 12% | 14% | 0.0% | 14% | 14% | 0.0% | 14% | 14% | 0.0% | 14% | 14% | 0.0% | 14% |
| 3 | Hospital Total Margin | 8.8% | 9.0% | 0.0% | 9.0% | 9.0% | 0.0% | 9.5% | 9.9% | 0.0% | 9.9% | 8.8% | 0.0% | 9.8% |
| D. | FTEs | 1,384 | 1,415 | - | 1,415 | 1,415 | - | 1,415 | 1,415 | - | 1,415 | 1,415 | - | 1,415 |
| E. | VOLUME STATISTICS | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 11,847 | 11,875 | | 11,875 | 11,816 | | 11,816 | 11,757 | | 11,757 | 11,698 | | 11,698 |
| 2 | Outpatient Visits | 238,522 | 246,611 | | 246,611 | 251,543 | | 251,543 | 256,574 | | 256,574 | 261,706 | | 261,706 |
| | TOTAL VOLUME | 250,369 | 258,486 | 0 | 258,486 | 263,359 | 0 | 263,359 | 268,331 | 0 | 268,331 | 273,404 | 0 | 273,404 |

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| EBIDA | $29,464 | $31,382 | $31,382 | $32,232 | $33,591 | $32,892 | $35,664 | $33,336 | $36,204 |
| | 11.5% | 12.1% | 12.1% | 12.1% | 12.6% | 12.0% | 13.0% | 11.8% | 12.9% |

NON-PROFIT

**Saint Mary's Hospital (only)**
**Financial Worksheet (A)**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| LINE | Total Entity: | (1) FY 2015 Actual Results | (2) FY 2016 Projected W/out CON | (3) FY 2016 Projected Incremental | (4) FY 2016 Projected With CON | (5) FY 2017 Projected W/out CON | (6) FY 2017 Projected Incremental | (7) FY 2017 Projected With CON | (8) FY 2018 Projected W/out CON | (9) FY 2018 Projected Incremental | (10) FY 2018 Projected With CON | (11) FY 2019 Projected W/out CON |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Description | | | | | | | | | | | |

**Assumptions**

| | |
|---|---|
| Total Gross Patient Revenue | 5.0% |
| Less: Allowances | 6.1% |
| Less: Charity Care | 5.0% |
| Less: Other Deductions | 5.0% |
| Less: Provision for Bad Debts | |

| | | |
|---|---|---|
| 14 | Less: Provision for Bad Debts | 5.0% |
| | Net Patient Service Revenue less provision for bad debts | |
| 15 | Other Operating Revenue | |
| 17 | Net Assets Released from Restrictions | |

| | |
|---|---|
| Salaries and Wages | 2.5% |
| Fringe Benefits | 2.5% |
| Physicians Fees | 3.0% |
| Supplies and Drugs | 5.0% |
| Depreciation and Amortization | 3.0% |
| Provision for Bad Debts-Other[b] | 2.0% |
| Interest Expense | -5.0% |
| Malpractice Insurance Cost | 2.0% |
| Lease Expense | 2.0% |
| Other Operating Expenses | 2.0% |

| | |
|---|---|
| NON-OPERATING REVENUE | 3% |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Medicare | 38.42% | 38.4% | | 38.4% | | 38.4% | | 38.4% | | 38.4% |
| Medicaid | 18.59% | 17.6% | | 17.6% | | 17.6% | | 17.6% | | 17.6% |

**Saint Mary's Hospital (only)**
**Financial Worksheet (A)**

**NON-PROFIT**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| LINE | Total Entity: | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FY 2015 | FY 2016 | FY 2016 | FY 2016 | FY 2017 | FY 2017 | FY 2017 | FY 2018 | FY 2018 | FY 2018 | FY 2019 |
| | | Actual | 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 |
| | CHAMPUS & TriCare | 0.08% | 0.7% | | | 0.7% | | | 0.1% | | | 0.1% |
| | Other | 0.00% | 0.0% | | | | | | | | | |
| | Total Government | 0.00% | 56.7% | | | 56.7% | | | 56.1% | | | 56.1% |
| | Commercial Insurers | 36.14% | 36.6% | | | 36.6% | | | 36.6% | | | 36.6% |
| | Uninsured | 3.33% | 3.3% | | | 3.3% | | | 3.3% | | | 3.3% |
| | Self Pay | 0.00% | 0.0% | | | 0.0% | | | 0.0% | | | 0.0% |
| | Workers Compensation | 3.04% | 3.0% | | | 3.0% | | | 3.0% | | | 3.0% |
| | Other | 0.40% | 0.4% | | | 0.4% | | | 0.4% | | | 0.4% |
| | Total Non-Government | 0.00% | 43.3% | | | 43.3% | | | 43.3% | | | 43.3% |
| | | 0.00% | 100.0% | | | 100.0% | | | 99.4% | | | 99.4% |

Saint Mary's Health System, Inc.
Financial Worksheet (A)

NON-PROFIT

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| LINE | Total Entity: Description | (1) FY 2015 Actual Results | (2) FY 2016 Projected W/out CON | (3) FY 2016 Projected Incremental | (4) FY 2016 Projected With CON | (5) FY 2017 Projected W/out CON | (6) FY 2017 Projected Incremental | (7) FY 2017 Projected With CON | (8) FY 2018 Projected W/out CON | (9) FY 2018 Projected Incremental | (10) FY 2018 Projected With CON | (11) FY 2019 Projected W/out CON | (12) FY 2019 Projected Incremental | (13) FY 2019 Projected With CON |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A2 | OPERATING REVENUE | | | | | | | | | | | | | |
| 1 | Total Gross Patient Revenue | $832,217 | $873,828 | | $873,828 | $917,519 | | $917,519 | $963,395 | | $963,395 | $1,011,565 | | $1,011,565 |
| 2 | Less: Allowances | $535,300 | $558,162 | | $558,162 | $592,210 | | $592,210 | $628,335 | | $628,335 | $666,663 | | $666,663 |
| 3 | Less: Charity Care | $1,854 | $2,500 | | $2,500 | $2,625 | | $2,625 | $2,756 | | $2,756 | $2,894 | | $2,894 |
| 4 | Less: Other Deductions | $4,232 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 | $9,746 | | $9,746 |
| | Net Patient Service Revenue | $290,831 | $303,420 | $0 | $303,420 | $312,938 | $0 | $312,938 | $322,558 | $0 | $322,558 | $332,262 | $0 | $332,262 |
| 5 | Medicare | $111,743 | $116,513 | | $116,513 | $120,168 | | $120,168 | $123,862 | | $123,862 | $127,589 | | $127,589 |
| 6 | Medicaid | $54,053 | $53,402 | | $53,402 | $55,077 | | $55,077 | $56,770 | | $56,770 | $58,478 | | $58,478 |
| 7 | CHAMPUS & TriCare | $226 | $2,124 | | $2,124 | $2,191 | | $2,191 | $2,258 | | $2,258 | $2,326 | | $2,326 |
| 8 | Other | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | Total Government | $166,024 | $172,039 | $0 | $172,039 | $177,436 | $0 | $177,436 | $182,891 | $0 | $182,891 | $188,392 | $0 | $188,392 |
| 9 | Commercial Insurers | $105,120 | $111,052 | | $111,052 | $114,535 | | $114,535 | $118,056 | | $118,056 | $121,608 | | $121,608 |
| 10 | Uninsured | $9,686 | $10,013 | | $10,013 | $10,327 | | $10,327 | $10,644 | | $10,644 | $10,965 | | $10,965 |
| 11 | Self Pay | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 12 | Workers Compensation | $8,849 | $9,103 | | $9,103 | $9,388 | | $9,388 | $9,677 | | $9,677 | $9,968 | | $9,968 |
| 13 | Other | $1,155 | $1,214 | | $1,214 | $1,252 | | $1,252 | $1,290 | | $1,290 | $1,329 | | $1,329 |
| | Total Non-Government | $124,810 | $131,381 | $0 | $131,381 | $135,502 | $0 | $135,502 | $139,668 | $0 | $139,668 | $143,869 | $0 | $143,869 |
| | Net Patient Service Revenue (Government+Non-Government) | $290,831 | $303,420 | $0 | $303,420 | $312,938 | $0 | $312,938 | $322,558 | $0 | $322,558 | $332,262 | $0 | $332,262 |
| 14 | Less: Provision for Bad Debts | $9,675 | $9,990 | | $9,990 | $10,490 | | $10,490 | $11,014 | | $11,014 | $11,565 | | $11,565 |
| | Net Patient Service Revenue less provision for bad debts | $281,156 | $293,430 | $0 | $293,430 | $302,449 | $0 | $302,449 | $311,544 | $0 | $311,544 | $320,697 | $0 | $320,697 |
| 15 | Other Operating Revenue | $8,248 | $7,253 | | $7,253 | $7,253 | | $7,253 | $7,253 | | $7,253 | $7,253 | | $7,253 |
| 17 | Net Assets Released from Restrictions | $733 | $733 | | $733 | $733 | | $733 | $733 | | $733 | $733 | | $733 |
| | TOTAL OPERATING REVENUE | $290,137 | $301,416 | $0 | $301,416 | $310,435 | $0 | $310,435 | $319,530 | $0 | $319,530 | $328,683 | $0 | $328,683 |
| B | OPERATING EXPENSES | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $123,041 | $132,928 | | $132,928 | $136,251 | | $136,251 | $139,657 | | $139,657 | $143,149 | | $143,149 |
| 2 | Fringe Benefits | $32,244 | $30,602 | | $30,602 | $31,367 | | $31,367 | $32,151 | | $32,151 | $32,955 | | $32,955 |
| 3 | Physicians Fees | $9,915 | $11,031 | | $11,031 | $11,362 | | $11,362 | $11,703 | | $11,703 | $12,054 | | $12,054 |
| 4 | Supplies and Drugs | $47,026 | $48,991 | | $48,991 | $51,441 | ($720) | $50,720 | $54,013 | ($1,512) | $52,500 | $56,713 | ($1,588) | $55,125 |
| 5 | Depreciation and Amortization | $11,502 | $11,713 | | $11,713 | $12,064 | | $12,064 | $12,426 | | $12,426 | $12,799 | | $12,799 |
| 6 | Provision for Bad Debts-Other[b] | | | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | Interest Expense | $979 | $231 | | $231 | $219 | | $219 | $208 | | $208 | $198 | | $198 |
| 8 | Malpractice Insurance Cost | $5,572 | $5,917 | | $5,917 | $6,035 | | $6,035 | $6,156 | | $6,156 | $6,279 | | $6,279 |
| 9 | Lease Expense | | | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Other Operating Expenses | $57,631 | $55,648 | | $55,648 | $56,761 | ($817) | $55,944 | $57,896 | ($1,621) | $56,275 | $59,054 | ($1,654) | $57,401 |
| | TOTAL OPERATING EXPENSES | $287,910 | $297,061 | $0 | $297,061 | $305,501 | ($1,538) | $303,963 | $314,211 | ($3,133) | $311,078 | $323,204 | ($3,241) | $319,960 |
| | INCOME/(LOSS) FROM OPERATIONS | $2,227 | $4,355 | $0 | $4,355 | $4,934 | $1,538 | $6,472 | $5,319 | $3,133 | $8,453 | $5,482 | $3,241 | $8,723 |
| | NON-OPERATING REVENUE | $2,190 | $2,877 | | $2,877 | $2,963 | | $2,963 | $3,052 | | $3,052 | $3,144 | | $3,144 |
| | EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES | $4,417 | $7,232 | $0 | $7,232 | $7,897 | $1,538 | $9,435 | $8,371 | $3,133 | $11,505 | $8,625 | $3,241 | $11,867 |

Saint Mary's Health System, Inc.
Financial Worksheet (A)

NON-PROFIT

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| LINE | Total Entity: | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FY 2015 | FY 2016 | FY 2016 | FY 2016 | FY 2017 | FY 2017 | FY 2017 | FY 2018 | FY 2018 | FY 2018 | FY 2019 | FY 2019 | FY 2019 |
| | | 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 | $3,000 | $3,000 | | $3,000 | $3,000 | | $3,000 | $3,000 | | $3,000 | $3,000 | | $3,000 |
| C. | PROFITABILITY SUMMARY | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | 0.8% | 1.4% | 0.0% | 1.4% | 1.6% | 0.0% | 1.6% | 1.6% | 0.0% | 2.6% | 1.7% | 0.0% | 2.6% |
| 2 | Hospital Non Operating Margin | 0.7% | 0.9% | 0.0% | 0.9% | 0.9% | 0.0% | 0.9% | 0.9% | 0.0% | 0.9% | 0.9% | 0.0% | 0.9% |
| 3 | Hospital Total Margin | 1.5% | 2.3% | 0.0% | 2.3% | 2.5% | 0.0% | 2.5% | 2.5% | 0.0% | 3.5% | 2.6% | 0.0% | 3.6% |
| D. | FTEs | 1,680 | 1,754 | | 1,754 | 1,754 | | 1,754 | 1,754 | | 1,754 | 1,754 | | 1,754 |
| E. | VOLUME STATISTICS | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 11,647 | 11,875 | | 11,875 | 11,816 | | 11,816 | 11,757 | | 11,757 | 11,698 | | 11,698 |
| 2 | Outpatient Visits | 238,522 | 246,611 | | 246,611 | 251,543 | | 251,543 | 256,574 | | 256,574 | 261,706 | | 261,706 |
| | TOTAL VOLUME | 250,169 | 258,486 | 0 | 258,486 | 263,359 | 0 | 263,359 | 268,331 | 0 | 268,331 | 273,404 | 0 | 273,404 |

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| EBIDA | $14,708 | $15,299 | $15,299 | $17,218 | $18,755 | $17,954 | $21,087 | $18,479 | $21,720 |
| | 5.1% | 5.4% | 5.4% | 5.5% | 6.0% | 5.6% | 6.6% | 5.6% | 6.6% |

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| LINE | Total Entity: | (1) FY 2015 Actual Results | (2) FY 2016 Projected W/out CON | (3) FY 2016 Projected Incremental | (4) FY 2016 Projected With CON | (5) FY 2017 Projected W/out CON | (6) FY 2017 Projected Incremental | (7) FY 2017 Projected With CON | (8) FY 2018 Projected W/out CON | (9) FY 2018 Projected Incremental | (10) FY 2018 Projected With CON | (11) FY 2019 Projected W/out CON | (12) FY 2019 Projected Incremental | (13) FY 2019 Projected With CON |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Description | | | | | | | | | | | | | |
| | **Assumptions** | | | | | | | | | | | | | |
| | Total Gross Patient Revenue | 5.0% | | | | | | | | | | | | |
| | Less: Allowances | 6.1% | | | | | | | | | | | | |
| | Less: Charity Care | 5.0% | | | | | | | | | | | | |
| | Less: Other Deductions | 5.0% | | | | | | | | | | | | |
| | Less: Provision for Bad Debts | | | | | | | | | | | | | |
| 14 | Less: Provision for Bad Debts | 5.0% | | | | | | | | | | | | |
| | Net Patient Service Revenue less provision for bad debts | | | | | | | | | | | | | |
| 15 | Other Operating Revenue | | | | | | | | | | | | | |
| 17 | Net Assets Released from Restrictions | | | | | | | | | | | | | |
| | Salaries and Wages | 2.5% | | | | | | | | | | | | |
| | Fringe Benefits | 2.5% | | | | | | | | | | | | |
| | Physicians Fees | 3.0% | | | | | | | | | | | | |
| | Supplies and Drugs | 5.0% | | | | | | | | | | | | |
| | Depreciation and Amortization | 3.0% | | | | | | | | | | | | |
| | Provision for Bad Debts-Other[b] | 2.0% | | | | | | | | | | | | |
| | Interest Expense | -5.0% | | | | | | | | | | | | |
| | Malpractice Insurance Cost | 2.0% | | | | | | | | | | | | |
| | Lease Expense | 2.0% | | | | | | | | | | | | |
| | Other Operating Expenses | 2.0% | | | | | | | | | | | | |
| | NON-OPERATING REVENUE | 3% | | | | | | | | | | | | |
| | Medicare | | 38% | 38.4% | | 38% | | | 38% | | | 38% | | |
| | Medicaid | | 19% | 17.6% | | 18% | | | 18% | | | 18% | | |
| | CHAMPUS & TriCare | | 0% | 0.7% | | 1% | | | 1% | | | 1% | | |
| | Other | | 0% | 0.0% | | 0% | | | 0% | | | 0% | | |
| | Total Government | | 0.0% | 56.7% | | 57% | | | 57% | | | 57% | | |
| | Commercial Insurers | | 36% | 36.6% | | 37% | | | 37% | | | 37% | | |
| | Uninsured | | 3% | 3.3% | | 3% | | | 3% | | | 3% | | |
| | Self Pay | | 0% | 0.0% | | 0% | | | 0% | | | 0% | | |
| | Workers Compensation | | 3% | 3.0% | | 3% | | | 3% | | | 3% | | |
| | Other | | 0.4% | 0.4% | | 0% | | | 0% | | | 0% | | |
| | Total Non-Government | | 0.0% | 43.3% | | 43% | | | 43% | | | 43% | | |

NON-PROFIT

Saint Mary's Health System, Inc.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LINE | Total Entity: | FY 2015 | FY 2016 | FY 2016 | FY 2016 | FY 2017 | FY 2017 | FY 2017 | FY 2018 | FY 2018 | FY 2018 | FY 2019 | FY 2019 | FY 2019 |
| | | 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 |
| | | 0.0% | 100.0% | | | 100% | | | 100% | | | 100% | | |

## Greer, Leslie

**From:** Schaeffer-Helmecki, Jessica
**Sent:** Friday, February 26, 2016 3:01 PM
**To:** Hartley, Christopher; 'banthony@stmh.org'
**Cc:** Greer, Leslie; Ciesones, Ron; Fernandes, David; Riggott, Kaila
**Subject:** Completeness Letter 2: 15-32045-CON
**Attachments:** 15-32045 Completeness Letter Two 2.26.16 FINAL.docx

Dear Mr. Hartley and Mr. Anthony:

Attached please find a second completeness letter for Trinity and Saint Mary's CON application (docket number 15-32045). Instructions for responding are included in the body of the attached letter. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact us. Have a good weekend.

**Jessica Schaeffer-Helmecki**
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

February 26, 2016

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: **Completeness Questions, Docket Number: 15-32045-CON**
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Hartley and Mr. Anthony:

On January 29, 2016, OHCA received responses from the Applicant to OHCA's completeness questions. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). OHCA has reviewed the CON application pursuant to Connecticut General Statutes §19a- 639a(c) and requests additional information.

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than **April 26, 2016**, otherwise your application will be automatically considered withdrawn.

Phone: (860) 509-8000 • Fax: (860) 509-7184
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

1. With regard to the "system overhead and system service allocations" referenced in section 3.10 of the Transfer Agreement dated September 18, 2015, provide an estimate of the charge and how it will be apportioned among members of New England-Regional Health Ministry ("NE-RHM"). What is the "appropriate metric" on which the fee is based? Additionally, to what allocations are other similarly-situated regional health ministries subject? Will the charge be constant from year to year or will it vary?

2. Will any future acquisitions of additional hospitals or health care facilities erode the capital available to Saint Mary's? If so, how will this affect the capital projects in which Trinity has proposed investing (i.e., new fluoroscopy imaging unit, primary back-up generator, upgraded breast imaging technology, etc.)?

3. Given the recently approved Johnson Memorial and Saint Francis-related CONs (docket numbers 15-31979 and 15-32002), respond to the following:

    a) Page 866 of the Applicant's response indicates that the $100 million capital commitment to Saint Mary's "is part of the $275 million capital commitment Trinity Health made to Saint Francis Care, Inc." How much of the original $275 million capital commitment has been earmarked solely for Saint Francis Care, Inc. and its related entities, such as Johnson Memorial?

    b) If the 8% cash flow margin is achieved, would the additional $20 million commitment abate the $275 million of capital commitments made to Saint Francis Care, Inc.?

    c) Did Trinity Health /NE-RHM know or have reason to know prior to August 31, 2015that up to $120 million of the $275 million committed for Saint Francis Care entities would be used for hospitals that were not yet affiliated with Saint Francis?

    d) Since the approval of CON 15-31979, has the Applicant made any additional capital commitments to NE-RHM as a result of the pending affiliation with the Saint Mary's Health System?

4. For the hospitals that Trinity Health has integrated into its system, has the financial performance (e.g., operating margin) improved as a result of their affiliations with Trinity? At what point in time after the affiliations did any financial impact specific to the Trinity affiliation begin to occur for each hospital? What financial impact on these hospitals continues to be experienced as a result of the ongoing affiliation with the Trinity Health system? Provide details for the following hospitals:

    a) Chelsea Community Hospital
    b) Mercy Health Systems
    c) St. Alphonsus Regional Medical Center
    d) Loyola University Health System
    e) Catholic Health East

f) St. Joseph Health, Inc.

5. Provide a detailed explanation for any increases or decreases in the price structure or average pricing and any changes to pricing policies following the Applicant's acquisition of:

   a) St. Alphonsus Regional Medical Center
   b) St. Francis Hospital and Medical Center
   c) Johnson Memorial Hospital
   d) St. Joseph Health, Inc.
   e) Loyola University Health Systems
   f) Mercy Health Systems

Please email your responses to all of the following email addresses: OHCA@ct.gov, OHCA@ct.gov, jessica.schaeffer-helmecki@ct.gov, kaila.riggott@ct.gov; david.fernandes@ct.gov; ron.ciesones@ct.gov.

If you have any questions concerning this letter, please feel free to contact us.

Sincerely,

Ron Ciesones
Health Care Analyst
Ron.Ciesones@ct.gov
(860) 418-7030

Jessica Schaeffer-Helmecki
Planning Analyst
Jessica.Schaeffer-Helmecki@ct.gov
(860) 509-8075

## Greer, Leslie

**From:** Schaeffer-Helmecki, Jessica
**Sent:** Friday, February 26, 2016 3:41 PM
**To:** Greer, Leslie
**Subject:** FW: Completeness Letter 2: 15-32045-CON
**Attachments:** Read: Completeness Letter 2: 15-32045-CON

Read Receipt

-----Original Message-----
From: Hartley, Christopher [mailto:CHartley@stfranciscare.org]
Sent: Friday, February 26, 2016 3:04 PM
To: Schaeffer-Helmecki, Jessica
Subject: Read: Completeness Letter 2: 15-32045-CON

NOTICE: This email and/or attachments may contain confidential or proprietary information which may be legally privileged. It is intended only for the named recipient(s). If an addressing or transmission error has misdirected this email, please notify the author by replying to this message. If you are not the named recipient, you are not authorized to use, disclose, distribute, make copies or print this email, and should immediately delete it from your computer system. Saint Francis Care has scanned this email and its attachments for malicious content. However, the recipient should check this email and any attachments for the presence of viruses. Saint Francis Care accepts no liability for any damage caused by any virus transmitted by this email.

Saint Mary's
HOSPITAL

March 11, 2016

Via Email

Jessica Schaeffer-Helmecki
Planning Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Completeness Responses for the Certificate of Need Application for Saint Mary's Health System, Inc. and Saint Mary's Hospital Inc.'s Transfer of Ownership and Control to Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find our responses to OHCA's February 26, 2016 letter regarding the above referenced Certificate of Need application. We are hopeful that these answers will allow us to move forward with Saint Mary's Hospital Inc.'s joining Trinity Health – New England, Inc. fka Saint Francis *Care* Inc.

As always should you have any questions regarding this response please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573.

Sincerely,

By: Robert Anthony /af
Robert Anthony
General Counsel
Saint Mary's Health System

By: Chris Hartley
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations
Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.

Enclosures

1. **With regard to the "system overhead and system service allocations" referenced in section 3.10 of the Transfer Agreement dated September 18, 2015, provide an estimate of the charge and how it will be apportioned among members of New England-Regional Health Ministry ("NE-RHM"). What is the "appropriate metric" on which the fee is based? Additionally, to what allocations are other similarly-situated regional health ministries subject? Will the charge be constant from year to year or will it vary?**

   The amount Trinity Health currently charges to Regional Heath Ministries (RHMs) is 0.8% of operating expenses which was reduced over the last few years from 1% of operating expenses. Typically, organizations are not subject to this charge until one year after the transaction has occurred; however, the services are available immediately. This is the case for Saint Francis, Johnson Memorial Medical Center, and Saint Mary's. The allocation methodology is consistent for all similarly-situated RHMs. For example, the NE-RHM will be charged $8.9 million annually beginning 10/1/2016 for Saint Francis and its subsidiaries. As the NE-RHM continues to grow, the charge will increase based upon the incremental operating expenses of new organizations (e.g., Saint Mary's) within the NE-RHM. The NE-RHM would then be responsible for allocating the charge to its local hospitals and other subsidiaries. This charge is calculated annually and we would anticipate the allocation would decrease as we become more efficient through integration with the NE-RHM. This overhead allocation is to cover the costs associated with corporate functions that both strategically and operationally benefit all hospitals and RHMs and include but are not limited to the following:

   - Clinically Integrated Networks (CIN) group helps to position the organization to develop and support CINs in every market and to establish market position for the future delivery model under accountable care.

   - Provider Network Operations provides executive leadership to support the employed physician practices and drive consistent practices in operating models. There are over 3,900 employed physicians and this team works on strategic direction, synergies in the practices, productivity, and provides a standard for creating efficiencies and compensation and practice productivity models.

   - Clinical Resources group provides support and coordination of standard clinical practices and protocols, clinical analytics to evaluate and improve clinical scorecard indicators, Tiger teams to develop improvements, and clinical collaboratives for areas such as sepsis, falls, pressure ulcers, congestive heart failure, labor and delivery, etc.

   - Tax department is responsible for preparation and consulting for all federal, state and local tax compliance and is responsible for all in-house consulting and 990 and 1120 tax return preparation. The tax department is staffed by CPAs with extensive healthcare experience and provides support and coordination for any RHM under IRS or local tax audit.

   - External audit fees are included in the system allocation as the audit is performed on a

system-wide basis.

- The Organizational Integrity, Audit and Compliance department provides insourced services with strong compliance department talent, consistent compliance polices and education designed to support an effective compliance program. Organizational Integrity, Audit and Compliance strongly support RHMs on billing and coding. The internal audit department of CPAs supports local RHM management and governance to provide risk based internal audit assurance and also includes specialists in information technology internal audit.

- Legal Services provides insourced legal support for all corporate legal services including merger and acquisitions, joint ventures, physician contracts, contracting with vendors for non-labor and employee labor relations.

These system departments will reduce the amount of direct expenses Saint Mary's, Saint Francis, and Johnson Memorial Medical Center have incurred historically as many of these resources were outsourced to accounting, legal, and consulting firms.

2. **Will any future acquisitions of additional hospitals or health care facilities erode the capital available to Saint Mary's? If so, how will this affect the capital projects in which Trinity has proposed investing (i.e., new fluoroscopy imaging unit, primary back-up generator, upgraded breast imaging technology, etc.)?**

   No, future acquisitions will not erode the capital available to Saint Mary's.

3. **Given the recently approved Johnson Memorial and Saint Francis-related CONs (docket numbers 15-31979 and 15-32002), respond to the following:**

   a) **Page 866 of the Applicant's response indicates that the $100 million capital commitment to Saint Mary's "is part of the $275 million capital commitment Trinity Health made to Saint Francis Care, Inc." How much of the original $275 million capital commitment has been earmarked solely for Saint Francis Care, Inc. and its related entities, such as Johnson Memorial?**

      As noted on page 635 of the Saint Francis CON, "The capital expenditure commitment made to Saint Francis *Care* will be available to support the capital needs of Saint Francis *Care*, including for the strategic growth and infrastructure development of the new RHM's integrated delivery system, the expansion and upgrade of the health care services provided by the new RHM, the support of community health/population management initiatives, and for strategic growth including potential mergers, acquisitions, joint ventures and physician network development." The NE-RHM determined that Saint Mary's is an important element for its strategic growth and, as such, has determined a portion of the $275 million capital commitment to SFC will be allocated to Saint Mary's. SFC is in full support of this strategic investment.

b) **If the 8% cash flow margin is achieved, would the additional $20 million commitment abate the $275 million of capital commitments made to Saint Francis Care, Inc.?**

If the 8% cash flow margin is achieved and Saint Mary's receives an additional $20 million of capital commitment, then it would be considered part of the $275 million of capital commitments made to SFC. Again, SFC believes Saint Mary's is an important strategic investment and has chosen to invest a portion of its capital in Saint Mary's.

c) **Did Trinity Health /NE-RHM know or have reason to know prior to August 31, 2015 that up to $120 million of the $275 million committed for Saint Francis Care entities would be used for hospitals that were not yet affiliated with Saint Francis?**

Yes, as noted in 3 a) above, Trinity Health/NE-RHM had planned for capital expenditures committed for Saint Francis *Care* to be available for "strategic growth including potential mergers, acquisitions, joint ventures and physician network development." Of key importance to Saint Francis *Care* was joining Trinity Health to allow access to capital to support its goal of strategic growth and expansion within Connecticut and the region. Saint Mary's and Johnson Memorial represent such investments.

Please note, however, although Trinity Health/NE-RHM hoped both organizations referenced above would join its health system, there were both federal and state regulatory and legal approvals as well as independent Board approvals that had to occur before either organization could join NE-RHM.

d) **Since the approval of CON 15-31979, has the Applicant made any additional capital commitments to NE-RHM as a result of the pending affiliation with the Saint Mary's Health System?**

No additional capital commitments have been made.

4. **For the hospitals that Trinity Health has integrated into its system, has the financial performance (e.g., operating margin) improved as a result of their affiliations with Trinity? At what point in time after the affiliations did any financial impact specific to the Trinity affiliation begin to occur for each hospital? What financial impact on these hospitals continues to be experienced as a result of the ongoing affiliation with the Trinity Health system? Provide details for the following hospitals:**

a) Chelsea Community Hospital
b) Mercy Health Systems

c) St. Alphonsus Regional Medical Center
d) Loyola University Health System
e) Catholic Health East
f) St. Joseph Health, Inc.

Overall, performance of these hospitals has benefitted from their affiliation with Trinity Health. Examples of specific savings that have been realized in these transactions are as follows:

- Chelsea Community Hospital, Chelsea, Michigan – Tangible benefits included:

    - Revenue growth of 40% between FY 2011 and FY 2016 driven by improved mix associated with surgery volume growth, practice acquisitions and outpatient growth.

    - Best practice outcomes in patient satisfaction, employee engagement and physician satisfaction.

    - Significant site capital investments based on its Master Facility Plan (e.g. new tower including conversion to private acute beds, expanding surgery and increasing ancillary and support space to backfill areas) have occurred totaling approximately $67M to improve environment of care and competitiveness.

    - Operating margin improved from 0.6% pre-merger to 4.4% currently

- Mercy Health, Hackley Campus – (Formerly Hackley Health System), Muskegon, Michigan - annual aggregate savings of $1 million, including from enhanced revenue management and reduced supply and vendor costs. Recently, Healthgrades announced hospitals that received Healthgrades 2016 America's Best Hospitals Award; Mercy Health – Hackley Campus received this award. Mercy Health – Hackley Campus reported an operating margin of -1.0% for the year ended June 2009, the first full year after they joined Trinity Health. Operating margin has improved substantially since then and for the year ended June 2015, Mercy Health – Hackley Campus reported operating margin of 10%.

- Three hospitals owned by Catholic Health Initiatives (Mercy Medical Center, in Nampa, ID; Holy Rosary Medical Center, in Ontario, OR; and St. Elizabeth Health Services, in Baker City, OR) were combined with Trinity Health's

Regional Medical Center in Boise, Idaho to create a new Regional Health Ministry, St. Alphonsus, which resulted in:

- Stabilizing financial performance across the region and specifically at Nampa campus with Operating Cash Flow Margin currently at 16.3%, up from 6.4% in FY 11. Operating margin is also strong and is currently at 9.8%.

- Successfully implemented Cerner EMR system at all three campuses in FY 13.

- Over $225M in investments are planned for relocation of the Nampa campus, which was in need of significant improvements, to a new location that would capture a broader patient base (easier patient access) and enhance physician recruitment and satisfaction.

- Loyola University Health System, Maywood, Illinois - In the first year of joining Trinity Health, Loyola improved its operational performance by $44.5 million across support functions including insurance/risk management, organizational integrity, supply chain, treasury, information services and revenue cycle. Additionally, operating margin and operating cash flow margins have improved substantially over time from -1.4% and 4.0%, respectively, at the time of the transaction, to 1.2% and 6.5% in fiscal 2015.

Also, as noted on page 872 of Docket No: 15-32045-CON cost savings have been realized as a result of the system-level merger with Catholic Health East as well as the recent acquisition of St. Joseph Health located in Syracuse, New York.

Timing of realization of savings is different in all cases; however, Trinity Health focuses on planning for and realizing savings as soon as possible after acquisition. Once savings are realized in a given year, those savings typically continue into the future. Trinity Health and its Regional Health Ministry's continuously look for opportunities for improvement in performance, whether related to Trinity Health system initiatives or strategic initiatives in the local markets. The recent acquisitions and other Trinity Health hospitals continue to benefit from Trinity Health's strong financial position which is supported by Trinity Health's ability to maintain strong ratings for several years. Most recent ratings are:

Moody's – Aa3, stable outlook, 12/21/15, S&P – AA-, stable outlook, 12/23/15, Fitch – AA, negative outlook, 12/30/15.

Although significant positive operational and financial results are realized, these hospitals as well as local hospitals in Connecticut are continuously challenged with decreasing reimbursement from both government and commercial payors and declining volumes. These external factors make it even more critical for local hospitals to leverage some of the resources of a larger health system.

5. **Provide a detailed explanation for any increases or decreases in the price structure or average pricing and any changes to pricing policies following the Applicant's acquisition of:**

    a) St. Alphonsus Regional Medical Center
    b) St. Francis Hospital and Medical Center
    c) Johnson Memorial Hospital
    d) St. Joseph Health, Inc.
    e) Loyola University Health Systems
    f) Mercy Health Systems

Pricing changes are operational in nature and are made as part of ongoing business decisions and are not made as a result of Trinity Health acquisitions. None of these acquisitions were made in order to increase or decrease the price structure of the entity. For Saint Francis Hospital and Medical Center, Johnson Memorial Hospital, St. Joseph Health, Inc., Loyola University Health System and Mercy Health Muskegon - Hackley campus, which is part of Mercy Health, there were no changes in price structure resulting from the acquisition. St. Alphonsus Medical Center – Nampa (Nampa, ID), part of the St. Alphonsus Regional Health Ministry did increase prices by approximately 12% following its acquisition as prior to the acquisition Nampa prices had not been increased for four years.

## Greer, Leslie

**From:** Fernandes, David
**Sent:** Wednesday, April 06, 2016 11:10 AM
**To:** chartley@stfrancis.org; banthony@stmh.org
**Cc:** Schaeffer-Helmecki, Jessica; Riggott, Kaila; Greer, Leslie; Ciesones, Ron
**Subject:** CON-32045 Deemed Complete
**Attachments:** 15-32045-CON Notification of Application Deemed Complete.docx

Dear Mr. Hartley and Mr. Anthony:

Please see the attached letter deeming complete the above reference application. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact me.

Thanks,

**David Fernandes**
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

# STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 6, 2016

Via Email Only

chartley@stfrancis.org
Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

banthony@stmh.org
Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry

Dear Mr. Hartley and Mr. Anthony:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of April 5, 2016.

If you have any questions concerning this letter, please feel free to contact either me at (860) 418-7032, Jessica Schaeffer-Helmecki at (860) 509-8075 or Ron Ciesones at (860) 418-7030.

Sincerely,

*David Fernandes*

David Fernandes
Planning Analyst (CCT)

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

## Greer, Leslie

**From:** Greer, Leslie
**Sent:** Monday, April 18, 2016 4:19 PM
**To:** 'chartley@stfranciscare.org'; 'BAnthony@Stmh.org'
**Cc:** Fernandes, David; Schaeffer-Helmecki, Jessica; Ciesones, Ron
**Subject:** Saint Mary's Health System, Inc. and Trinity Health, Inc. Hearing Notice
**Attachments:** 32045_201604181610.pdf

Mr. Hartley & Mr. Anthony,
Attached is the hearing notice for the Saint Mary's Health System, Inc. and Trinity Health, Inc. scheduled on May 9, 2016.

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
## 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

April 18, 2016

Christopher Hartley
Senior Vice President Planning
Business Development & Government Relations
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

RE: Certificate of Need Application, Docket Number 15-32045-CON
Saint Mary's Health System, Inc., and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

Dear Mr. Hartley,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Saint Mary's Health System Inc. and Trinity Health, Inc. ("Applicants") on April 5, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant(s): Saint Mary's Health System, Inc.
Trinity Health, Inc.

Docket Number: 15-32045-CON

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

Notice is hereby given of a public hearing to be held in this matter to commence on:

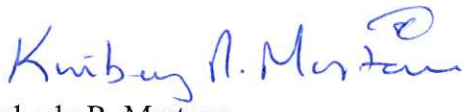
Date: May 9, 2016

Time: 3:00 p.m.

Place: Courtyard by Marriott Waterbury
63 Grand Street
Waterbury, CT 06702

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Republican American* pursuant to General Statutes § 19a-639a (f).

Sincerely,



Kimberly R. Martone
Director of Operations
Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:DF:JSH:RC:lmg

# 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

April 18, 2016 P.O. #54772

Republican American
389 Meadow Street
P.O. Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, April 20, 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 there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association
KRM:DF:JSH:RC;lmg

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

Republican American
Notice of Public Hearing, Docket Number 15-32045-CON

April 18, 2016

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

| | |
|---|---|
| Statute Reference: | 19a-638 |
| Applicant(s): | Saint Mary's Health System Inc.<br>Trinity Health Inc. |
| Town: | Waterbury |
| Docket Number: | 15-32045-CON |
| Proposal: | Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc. |
| Date: | May 9, 2016 |
| Time: | 3:00 p.m. |
| Place: | Courtyard by Marriott Waterbury<br>63 Grand Street<br>Waterbury, CT 06702 |

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 4, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

## Greer, Leslie

**From:** ADS <ADS@graystoneadv.com>
**Sent:** Monday, April 18, 2016 4:24 PM
**To:** Greer, Leslie
**Subject:** Re: DN: 15-32045-CON Hearing Notice

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

***Don't forget to ask for ideas to expand your diversity coverage.***

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

***E-mail new ad requests to: ads@graystoneadv.com***
http://www.graystoneadv.com/

---

**From:** "Greer, Leslie" <Leslie.Greer@ct.gov>
**Date:** Monday, April 18, 2016 at 4:09 PM
**To:** Ads Desk <ads@graystoneadv.com>
**Subject:** DN: 15-32045-CON Hearing Notice

Please run the attached hearing notice in the Republic American by 4/20/16. For billing purposes, refer to P.O. 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

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*

## Greer, Leslie

**From:** Robert Taylor <RTaylor@graystoneadv.com>
**Sent:** Tuesday, April 19, 2016 4:57 PM
**To:** Greer, Leslie
**Subject:** FW: DN: 15-32045-CON Hearing Notice
**Attachments:** 15-32045 Republican American.docx

Good afternoon,

This notice is set to publish tomorrow.
$190.83

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

---

**From:** ADS <ADS@graystoneadv.com>
**Date:** Tue, 19 Apr 2016 09:27:42 -0400
**To:** RTaylor <rtaylor@graystoneadv.com>
**Subject:** FW: DN: 15-32045-CON Hearing Notice

---

**From:** "Greer, Leslie" <Leslie.Greer@ct.gov>
**Date:** Monday, April 18, 2016 at 5:24 PM
**To:** Ads Desk <ads@graystoneadv.com>
**Subject:** RE: DN: 15-32045-CON Hearing Notice

Attached is the word version.

---

**From:** ADS [mailto:ADS@graystoneadv.com]
**Sent:** Monday, April 18, 2016 4:30 PM
**To:** Greer, Leslie
**Subject:** Re: DN: 15-32045-CON Hearing Notice

Good day,

Thank you for your ad request.

**We can not pull the text off of the attachment, please re-send asap.**

Thank you
Graystone Group Advertising

**From:** "Greer, Leslie" <Leslie.Greer@ct.gov>
**Date:** Monday, April 18, 2016 at 4:09 PM
**To:** Ads Desk <ads@graystoneadv.com>
**Subject:** DN: 15-32045-CON Hearing Notice

Please run the attached hearing notice in the Republic American by 4/20/16. For billing purposes, refer to P.O. 54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

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*

## Real Estate For Rent

**Apartments**
**Condos**
**Garages**
**Houses**
**Mobile homes**
**Motels & hotels**
**Out-of-town**
**Rental services**
**Roomates**
**Rooms**
**Storage**
**Suburban**
**Vacation**
**Wanted to rent**

## Apartments for rent

APTS FOR RENT-WATERBURY
**SECTION 8 WELCOME**
2-3 BR, BEACON ST
3 BR, 19 TAYLOR ST
3 BR, 131 OAK ST
Se habla espanol
**JOEL ROSARIO, Owner/Broker**
**Call Today 203-217-2593**
A Home Connection R.E

**NAUGATUCK** 1 bedroom $725; Prospect Manor, lndry, storage, prkg, nice sec/ref. 203-753-3239

**NAUGATUCK** 3 BR, 6rms 1st floor 11 Maple Terrace, No pets. 1st, last, security. Call 203-725-5823

**NAUGATUCK** duplex 3 BR appl, W/D hkup, 2 baths, gar, no pets / smk $1200+sec 203-758-4327

**OAKVILLE** 1br 2nd flr, no smoke/no pets, H/HW elec., stove/fridge incl., close to Rte 8. $850+1 mo sec. **860-274-5841**

**WATERBURY** 1, 2, 3 & 4 BR apts. available. Property Management Center (203) 755-6649.

**WATERBURY** 1, 2, 3, 4 BR Apts & Houses available **NEWLY RENOVATED** Agent 203-565-9639

**WATERBURY** 1, 2 & 3 rm apts clean, appl, util secure bldg lndry $465/up. Sect 8 OK. 203-753-3239

**WATERBURY** 1, 2 & 3 rms, nice, heat & appl, secure building, prkg, $450 & up (203) 206-4051

**WATERBURY $1200** 4 BR, brand new - just rebuilt. 1½ baths, convenient to I-84. **Velezis Realty, 203-574-7777.**

WATERBURY 174 Willow St. **studios, 1br** start @ $450 H/HW incl Sect 8 ok. 203-510-6177

WATERBURY **1BR, 2BR, 3BR** available starting @ $550. Section 8 accepted. 203-510-6177

**WATERBURY** 1BR & 2BR, No pets, on-site laundry. Starting at $650. Call 860-810-2941

**WATERBURY 1BR** *Must see, new!* Cabinets, appl, Priv, off st pk, no smk/pets $750 neg. 203 756 1140

**WATERBURY** 3 & 4 BR Chestnut Av WD hkups, remod, clean, no pets. Sec 8 $875 & up. 203-558-5142

**WATERBURY** 3 BR 199 Chestnut Ave., 3rd flr., large rooms, quiet, no pets, $750/mo. 203-722-7171

**WATERBURY** 3 BR, nice, HW floors, heat, parking & laundry included $800 (203) 206-4051

**WATERBURY**
**5 RM/2 BR** Town Plot - very spacious, hardwood floors. 1st floor **$850**, 2nd floor **$825**.
**5RM/2 BR** Town Plot - 1st flr, **$800**
**4 RM/2 BR** 1st and 2nd floor, 4-plex Town Plot, **$800**
**OAKVILLE**
**6 RM/3 BR Raised Ranch** - finished basement, 1 car garage. Sm. dog considered. **$1,500**
**Farmingbury Real Estate**
**203-879-6491**

**WATERBURY** 98 Rose St. 3BR hardwood floors, gar., yard, $850+sec. Call 203-756-6339.

## Apartments for rent

**WATERBURY DOWNTOWN** Beautiful renov. apts. in modern 10 story fireproof Elev. Bldg. w/great views; 1 BR $610; Low rentals incl: 1 Parking Space, Carpet/HW Flr., Security / Lndry Rm. No Pets. Habla Espanol. Mgmt: 203-756-1999; 203-837-7428

**WATERBURY**
**EAST END APTS.** some newly renovated, on busline, convenient to shopping, laundry on premises. $650-$675. Credit check. 203-725-6121

**WATERBURY** Giles St. 2BR, 1 bath, LR, DR, sunroom, gar. incl. gas heat, $890 No utils. 203-769-0898

**WATERBURY** Must see 1st flr. 2BR apt quiet dead end, W/D incl, Lg. inside porch, $750. 860 997 5468

**WATERBURY** spacious studio & 1BR & 2BR. $625, $750 & $850. Call for details 203-906-0817

**WATERBURY STUDIO & 1 BR**
41 Prospect St. Subsidized unit
Call Cristina 203-509-2025
Call Rose 203-560-9702

**WATERBURY** Town Plot 1st flr 2BR, appls incl, No pets. $875+2mos sec. 203-232-4693

WATERBURY **Town Plot** 2br $850. & **Hopeville** 2br $795. Call 203-729-2269, 203-805-1680

**WATERBURY** Town Plot 2BR, appl WD hkup, w/w, busline, no pets $850 cr ck sec 860-274-9554

**WATERBURY** Town Plot, 5RM 2nd floor, fresh paint, hdwd flrs. 649 Wilson St. No pets. 860-378-5877

**WATERBURY** Town Plot huge modern 8 rms, quiet nghbrhd, no pets, good ref. & cr. check $1100/mo. **914-906-5489**

**Waterbury/Wolcott Line**
Mod. elev. bldgs convenient well maintained **HILLTOP MANOR** Studios $570; 1 BR from $670; **LIBERTY COURT** heat, HW, elect. incl.; studios $650+; 1 BR $790+; Both incl. prkg., carpet/HW flrs, sec. & laundry. No pets. **Mgmt:** 203-755-0621; 203-470-9808

## Condos for rent

WATERBURY 2BR Condo. W/D, $775 & up + sec. Sec 8 ok, No pets. 203-879-4126; 203-577-7516

## Houses for rent

**WATERBURY** single family E.End, Overlook, Bunker Hill, South End Starting @ $1200 203-510-6177

## Roommates

**ROOMMATE WANTED** clean, quiet, responsible, West Side of Naug. $900/mo. 860-830-5710,

## Rooms

**WATERBURY** 27 Johnson St, furn room, mens rooming house, sec/clean bldg./ shared bath/ all util & cable inc/$125 wk & up, sec/ref chk req. 203.444.7252

**Waterbury** East End starting at $125 wk. Shared kit & bath, $400 sec. **Velezis Realty 203-574-7777**

**WATERBURY** furnished bedroom, $650/month. Utilities included. 203-753-3388

## Rooms

**WATERBURY FURNISHED ROOM** non-smoking. Call 203-524-6146

**WOODBURY** rooms for rent, no smoke, call George 203-266-4360

## Real Estate For Sale

## Houses

**PROSPECT** 176 Scott Rd to settle estate 3BR, 1.5 bath, garage, level lot, new roof & furnace. Easy access to 84. Low taxes, excel Schools. Asking $190,00. Call 203-233-0518 for Appointment.

## Lots for sale

**BANTAM LAKE** (2) bldg lots on 5 ac priv. community. Tennis, boat, water & sewer incl. 860-868-1256

**MIDDLEBURY LAND** $87,000 or best, 20.49 acres, parcel ID 7-02-028, Benson Rd, **860-307-3695**

## Mobile home

**NAUGATUCK** spacious 2 BR, 1.5 baths, newly remod. **$32,900** Liberty 860-747-6881 860-940-1204

**PROSPECT** new 2BR 2 bath easy access thru-out **$87,500** LIBERTY 860-747-6881; 203-592-7641

## Commercial

**Business for sale**
**Commercial for sale, lease, rent**

## Commercial for sale, lease, rent

**WATERBURY** medical office space 1200sf handicap access great location 203-206-4051

**WATERTOWN** Prime business location for Lease, two spaces from $750 and up, parking lot attached, Call Nico 203-206-3360

**WOLCOTT Hair Salon/Barber Shop for Lease.**
Excellent Location, turnkey operation, all equip. incl. Call John for more info 203-509-2939

## Announcements

**Absolutely free**
**Lost & found**
**Special notices**

## Absolutely free

**HOT TUB** 6 person w/outdoor circuit breaker & wire. Needs cover (approx $300); you haul away Wtby. 203-910-5947

**STOVE** (white) electric, works great. Call 860-274-0016 after 10:00am.

## Lost & found

**IMPOUNDED NAUG** #112 m, pit bull beagle mix, brown & white Spring St 203-729-4324.

## Lost & found

**LOST CAT** Young M Neut. Tabby, drk gray w/ light gray/tan markings. Lost near Lorann Dr. Naugatuck. 203-623-1318

## Legals/ Public Notices

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

The Board of Finance and the Board of Councilmen of the City of Torrington will hold a Public Hearing on Monday, May 2, 2016 immediately following the Special Joint Meeting of the Board of Finance and the Board of Councilmen and the two previous public hearings that start at 6:30 p.m. in the City Hall Auditorium, 140 Main St., Torrington, CT on the proposed 2016-2017 budget (except the school budget).

Copies of the proposed budget will be available at the office of the City Comptroller, and the City Clerk, prior to the hearing.

The public is invited to attend and to submit written or oral comments and questions on the budget.

Dated at Torrington, CT, this 20th day of April, 2016.

BOARD OF FINANCE
BOARD OF COUNCILMEN
CITY OF TORRINGTON

Joseph L. Quartiero, CMC
City Clerk
R-A April 20, 2016

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CITY OF TORRINGTON
PLANNING AND ZONING COMMISSION
LEGAL NOTICE

The Planning and Zoning Commission has scheduled a public hearing on the following application on Wednesday, April 27, 2016 at 7:30 p.m. in the City Hall Council Chambers, Room 218, 140 Main Street, Torrington, CT:

a. Special Exception 16-305 and Site Plan 1178

Applicant: Greenstone, LLC
Location: 70 North Street
Proposal: Special Exception for storage of more than 100 cubic yards of earth materials; and site plan for vehicle parking and equipment storage outside of enclosed structure

A copy of the above mentioned proposal is on file in the Land Use Office, Room 324, City of Torrington, 140 Main Street, Torrington, CT

Richard Calkins, Chairman
Planning and Zoning Commission

Dated in Torrington, CT
this 13th day of April 2016

R-A April 13 & 20, 2016

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NOTICE TO CREDITORS
ESTATE OF Marian S. Mezzio, of Naugatuck, AKA Marian Mezzio, AKA Marion Mezzio, (16-00097)

The Hon. Peter E. Mariano, Judge of the Court of Probate, District of Naugatuck Probate Court, by decree dated March 15, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Patricia Alegi, Chief Clerk

The fiduciary is:
Richard Mezzio
c/o Atty James C. Winters
Winters & Winters
315 Highland Avenue, Suite 102
Cheshire, CT 06410

R-A April 20, 2016

## Legals/ Public Notices

CITY OF TORRINGTON
PLANNING AND ZONING COMMISSION
LEGAL NOTICE

At its April 13, 2016 meeting, the Planning and Zoning Commission acted on the following applications:

a. Special Exception 16-307
Applicant: The McCall Foundation, Inc.
Location: 417 Prospect Street

Proposal: Group Care Facility, 7 – 12 beds
DECISION: Approved with conditions.

b. Location Approval and Site Plan 1183
Applicant:
CAO Enterprises LLC
Location: 2101 Winsted Road
Proposal: Repairer's license, Location Approval
DECISION: Approved

c. Special Exception 16-308
Applicant: Brian Butler
Location: 478 Norfolk Road
Proposal: Construct residential addition within front yard setback
DECISION: Approved with conditons

d. Zoning Regulations Amendment
Applicant: City of Torrington Planning and Zoning Commission
Proposal: Zoning Regulations, Amendments to Section 7.2, Flood Hazard Regulations

DECISION: Approved.
The effective date of the Zoning Regulation Change shall be April 21, 2016.

Copies of the above applications and plans are on file in the Land Use Office, City of Torrington, 140 Main Street, Torrington, CT

Richard Calkins, Chairman
Planning and Zoning Commission
Dated in Torrington, CT
this 20th day of April, 2016
R-A April 20, 2016


**READY FOR A NEW POSITION?**

**Check us out in print and online, you'll soon find there's opportunity in the Classifieds!**
RepublicanAmerican


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Legal Notice
Town of Winchester
Zoning Board of Appeals
Public Hearing

The Town of Winchester Zoning Board of Appeals will hold its meeting. A Public Hearing on April 26th, 2016, 7:00 p.m. in the P. Francis Hicks Room, 2nd floor Town Hall, 338 Main St., Winsted, CT to act on the following:

#16-5167 Request for variance from section 4.2 Frontyard Setback at 65 Oakdale Ave.

Interested parties may appear and be heard.
Dated this 11th day of April 2016
David Villa, Chairman
Zoning Board of Appeals
R-A April 14 & 20, 2016

## Legals/ Public Notices

LEGAL NOTICE
WARNING
ANNUAL TOWN BUDGET MEETING
TOWN OF WINCHESER, CONNECTICUT
Monday, May 2, 2016

Warning to all persons entitled to vote in Town Meetings of the Town of Winchester, County of Litchfield, and the State of Connecticut are hereby notified and warned that the Annual Budget Meeting of said Town will be held in The Gilbert High School Auditorium, 200 Williams Ave., in said Town, on Monday, May 2, 2016 at 7:00 p.m. for the following purpose to Wit:

1). To receive a report of the Board of Selectmen including its estimates of receipts and expenditures and its recommendation in accordance with the law and to take action upon the same and to adopt a budget for the Town for the next Fiscal Year commencing July 1, 2016

2). To take any action proper to come before said meeting.
Dated at Winchester, this April 19, 2016
Received by Sheila S. Sedlack, Town Clerk
RA April 20, 2016


**Remodel It Right!**
Find Help In The
**At Your Service Directory**
Every Day In The
RepublicanAmerican
Classifieds!


## MOTHER'S DAY CONTEST

### OFFICIAL CONTEST RULES

1. Submit your name, address and phone on an official entry blank. Entry form must be completely filled out. No photo copies will be accepted. All entries, dropped off or mailed, must be in a sealed envelope. Enter as often as you like. All entries will be eligible for the Grand Prize drawing.
2. Mail entries to: **MOTHER'S DAY CONTEST, P.O. Box 2000, Waterbury, CT 06722-2000.** Entries must bear proper postage. Only one entry per envelope. No payments or business correspondence should be mailed to this address.
3. No purchase necessary. Entry blanks published daily in the Republican-American *OR* are available at the Republican-American main office located at 389 Meadow Street, Waterbury.
4. All entries must be received by May 6, 2016. Grand prize drawing will be May 6, 2016. Winner will be notified by phone and winner's name will be published in the Republican-American on Sunday, May 10, 2015. Winner must appear in person during the hours of 9am and 5pm within seven business days *(Saturday and Sunday excluded)* from the date they are notified. The Grand Prize winner must be able to provide proper identification with the correct address as it appears on the official winning entry form.
5. Winner is responsible for applicable federal, state and local taxes.
6. Winner automatically permits the use of their name, address and photo for Republican-American promotional purposes.
7. Employees of the Republican-American, TeleReach, Inc. as well as their immediate families, are not eligible.
9. Participants must be 18 years of age or older.
10. Void where prohibited by law.
11. Odds of winning determined by the number of entries received.

## Legals/ Public Notices

Notice of Permit Application
Municipality: Waterbury, CT

Notice is hereby given that F&G, LLC (the "applicant") of 15 Mullen Road, Enfield, CT is submitting, to the Department of Energy & Environmental Protection, an application under Connecticut General Statutes Section 22a-208a for a new permit for operation of solid waste facilities. The facility address is 260 Railroad Hill Street, Waterbury, CT.

The existing facility is currently permitted as a Single Item Recycling Facility for acceptance and processing of recyclable materials. The purpose of this new permit is to increase the processing capacity to 700 tons per day and to add the acceptance and transfer of municipal solid waste(MSW), the volume reduction of Construction & Demolition debris, over-sized MSW and non-putrescible MSW, and to accommodate the acceptance, processing and transfer of singlestream recyclable materials in addition of the previously permitted solid waste material (recyclable paper).

Once completed, interested persons may obtain copies of the application from Anchor Engineering Services, Inc, 41 Sequin Drive, Glastonbury, CT 06033, telephone (860) 633-8770, contact T.J. Therriault, at cost.

Once submitted, the application will be available for inspection at the Department of Energy & Environmental Protection, Waste Engineering & Enforcement Division, 79 Elm Street, Hartford, CT 06106-5127, telephone (860) 424-3366, from 8:30 to 4:30 Monday through Friday.

R-A 4/20/16

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STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS
ORDER OF NOTICE

NOTICE TO: Kelli Smith; Mother of female children born on 10-11-07 and 9-14-12 and a male child born on 11-25-03 in town of Waterbury, CT

of parts unknown

A petition has been filed seeking:

Commitment of minor child(ren) of the above named or vesting of custody and care of said Child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person.

Hearing on an Order of Temporary Custody will be heard on: 4-22-16 at 11:00 a.m. at SCJM, 7 Kendrick Ave, 3RD Floor, Waterbury, CT 06702.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the: Waterbury Republican American, a newspaper having a circulation in the town/city of Waterbury, CT

Honorable Joseph W. Doherty
Judge

Renee Polletta, Office Clerk
Date signed 4-15-16

RIGHT TO COUNSEL: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your Hearing is to be held.
R-A April 20, 2016

## Legals/ Public Notices

CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN, that the Board of Councilmen of the City of Torrington will hold a public hearing on Monday, May 2, 2016, immediately following the previous public hearing starting at 6:30 p.m. in the City Hall Auditorium, 140 Main St., Torrington, CT on the lease of City of Torrington Property located at the Torrington Landfill, 105 Vista Drive in Torrington for the installation of a Solar Array Project. Sketches of the proposed project are available for public review in the City Clerk's Office.

All interested parties are invited to attend and be heard.

Dated at
Torrington, Connecticut,
this 20th day of April, 2016.

Joseph L. Quartiero, CMC
City Clerk
R-A April 20 & 25, 2016

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CITY OF TORRINGTON
NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the Board of Councilmen of the City of Torrington will hold a public hearing in the City Hall Auditorium, 140 Main Street, Torrington, CT, on Monday, May 2, 2016, at 6:30 p.m., with respect to the following proposed resolution:

Resolution Authorizing An Appropriation Of $4,100,000 For The East Basin Sewer Rehabilitation Project And The Financing of Said Appropriation By The Issuance Of Revenue Bonds, Notes And Obligations Of The City In An Amount Not To Exceed $4,100,000.

The full text of the proposed resolution is on file, and open to public in inspection, in the office of the City Clerk, 140 Main Street, Torrington, CT.

Dated at
Torrington, Connecticut,
this 20th day of April, 2016.

Joseph L. Quartiero, CMC
City Clerk
R-A April 20, 2016

## Legals/ Public Notices

NOTICE OF WARNING OF DISTRICT MEETING

All electors and citizens who are qualified to vote in town meetings of the Towns of Bethlehem and Woodbury, Connecticut, are hereby notified and warned that a District Meeting of Regional School District 14 will be held in the library of Nonnewaug High School, 5 Minortown Road, Woodbury, Connecticut, on Monday, May 2, 2016 at 7:30 p.m.PURPOSE: TO CONSIDER THE BUDGET SUBMITTED BY THE BOARD OF EDUCATION FOR REGIONAL SCHOOL DISTRICT NO. 14 FOR THE FISCAL YEAR COMMENCING JULY 1, 2016 AND ENDING JUNE 30, 2017 IN THE AMOUNT OF $ 33,154,406.The vote on said budget will be by the voting machines in the towns of Bethlehem and Woodbury, Connecticut on Tuesday, May 3, 2016, between the hours of 6:00 a.m. and 8:00 p.m., the day following the District Meeting.
BOARD OF EDUCATION
REGIONAL SCHOOL DISTRICT NO. 14
Bethlehem and Woodbury, Connecticut
BY: George Bauer, Chairperson
RA 4/20/2016

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TOWN OF LITCHFIELD
NOTICE OF PUBLIC HEARING OF THE BOARD OF FINANCE

The Board of Finance of the Town of Litchfield will hold a Public Hearing at the Litchfield Intermediate School Auditorium on Wednesday, April 27, 2016 at 7:00 p.m., at which itemized estimates of expenditures of the Town for the ensuing fiscal year shall be presented and at which all persons shall be heard in regard to any appropriation which they are desirous that the Board should recommend or reject.

Dated at Litchfield, Connecticut, this 11th day of April, 2016.

Helen RuwetBunnell
Anne Dranginis
Mitchell Fishman
Edward Gadomski
David W. Geiger
David W. Wilson

Board of Finance
Town of Litchfield
RA April 20, 2016

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Office of Health Care Access Public Hearings

Statute Reference: 19a-638
Applicant(s): Saint Mary's Health System Inc.
Trinity Health Inc.
Town: Waterbury
Docket Number: 15-32045-CON
Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.
Date: May 9, 2016
Time: 3:00 p.m.
Place: Courtyard by Marriott Waterbury
63 Grand Street
Waterbury, CT 06702

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 4, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.
R-A April 20, 2016

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**NOTICE**

Pursuant to General Statutes § 16-50p (a), the Connecticut Siting Council (Council) announces that, on April 14, 2016, the Council issued Findings of Fact, an Opinion, and a Decision and Order approving an application from The Connecticut Light & Power Company d/b/a Eversource Energy for a Certificate of Environmental Compatibility and Public Need for the Frost Bridge to Campville 115-kilovolt (kV) electric transmission line project that traverses the municipalities of Watertown, Thomaston, Litchfield, and Harwinton, which consists of (a) construction, maintenance and operation of a new 115-kV overhead electric transmission line entirely within existing Eversource right-of-way and associated facilities extending approximately 10.4 miles between Eversource's existing Frost Bridge Substation in the Town of Watertown and existing Campville Substation in the Town of Harwinton; (b) related modifications to Frost Bridge Substation and Campville Substation; and (c) reconfiguration of a 0.4 mile segment of two existing 115-kV electric transmission lines across the Naugatuck River in the Towns of Litchfield and Harwinton within the same existing right-of-way as the new 115-kV electric transmission line. This application record is available for public inspection in the Council's office, Ten Franklin Square, New Britain, Connecticut. 4/20/2016

# AT YOUR SERVICE DIRECTORY

## Appliance sales/repair

**Henry's Appliance Repair** We service all major brands & offer used appliances 203-632-8000

## Asphalt paving

**BRASS PAVING LLC** ~ CT#575141 Paving driveways, sealing & repairs. Free est. 203-574-2693

**MARINI PAVING** **860-274-3978**
* Driveways * Repairs
* Seal Coating * Drainage
#563045. 203-410-9226

**SPINO'S PAVING**
Comm'l and resid'l driveways, parking areas, plow damage repair and curbing replaced. Free estimates. Ct Lic #579761.
**203-574-2547 cell 203-537-3151**

**THEPURPLEPAVERS.COM**
One call for all your pavement needs! Visit us online to learn the 7 secrets for choosing a paving contractor CT# 612743. Call 860-945-0873 Visit Deziel Paving on Facebook to view our current project.

## Carpentry

**DN Carpentry** Window, doors, decks, baths, drywall, trim, paint, fin.bsmt. #614783, Ins. 203 233 0795

## Electrical

**Accurate Electrical**
Fully insured, Lic. E1-189172
203-509-7027

**DW ELECTRICAL** Any size jobs, srvc grounding, upgrades, rem. Free est #182995. 203-592-3562

## General services

**EMT PROGRAMS** Starting in May. For info call/email 203-632-9247 or mededstaff@mededct.com

## Gutters

**BAY KLEEN** Gutter cleaning & repair, powerwashing homes & decks 203-525-3890. #0643703

**PEET SEAMLESS GUTTERS & SERVICES**
860-283-2292

## Hauling services

**ALL ABOUT SERVICE**
**S&P CARTING** trash & cleanup 10-40 yard roll off containers. Same day svc. Ins V/MC **203-755-4656**

**JAY & EDDIE**
Junk removal & Lawncare.
Call 203-558-0488

**JUNK REMOVAL** furn., appliances, shed, attic, basement, piano removal, Spring cleanup, 20% off, 203-535-9817, 860-575-8218

## Home improvement

**BUDGET PAINTING & Remod** roofs, siding & painting, fully insured #0638113. Call 203-982-5353

**DREAM DECKS** by Advance Contrsuction of CT 100% Finanicing, no money down 30 yrs exp. #0644836. 203-788-3799

**PREMIER SERVICES** kit bths decks ceramic tile siding roofing fully ins fr est lic. 641592. **203-228-3750**

## Landscaping & lawns

**ALL LAWNCARE**
Spring has sprung. Spring cleaup, weekly lawn maint. All aspects of landscaping. Irrigation PLM0277997-P1. Fertlization program B2008. 203-755-4656

**B&D LANDSCAPING** landscaping, mowing, cleanups, trimming, com & res. #540877. Call 203-575-9282, 203-437-1641

**BUD'S LAWN CARE** cleanups, mowing, pruning, etc. FR. EST. Lic. #0645023; 203-558-9503

**CREST LAWN SERVICES**
mowing, and more. Reas. rates. Veteran. 203-509-6395

**DB LANDSCAPE** Lawn mowing Commr'l & Residential, mulching, trimming, stone work, free estimate, #0633401; 203-704-1640

**SCREENED LOAM** DARK, RICH FARM LOAM. PICKED UP OR DELIVERED. **203-879-2731**

## Landscaping & lawns

**Spring Cleanups/Property Maint.** Weekly cut. East Mtn., Prospect, Naugatuck areas. 203-232-6342

## Masonry

**A-1 JIMMY'S MASONRY** #604550. Walls, brick/ blue stone, steps, sidewalks, repairs & more. Free est. 203-982-0145/860-628-0455

**ALFRED MASONRY** 30+yr exp. Pools, deck, stamp conc, patios, retain. walls, stucco Ins #565904. Free est. Call 860-274-7977

**BELULI MASONRY**
Stone walls, fireplaces; Any size job; 203-695-8177; #HIC0565123

**EXCEPTIONAL MASONRY**
Pavers, stonework, chimneys, waterproofing, repairs, free estimates 0638978. 860-922-8922

**F&R Masonry** Walls, Patios, steps, walks, chimney, repairs, etc. *Free Est.* #0637257 ins. **203-805-9114**

FINELINE MASONRY Stamped Concrete,Patios,Walkways,Stonewalls, #0640314; 860-378-5877

**JIMMY MASONRY** Masonry stone, brick, steps, sidewalks, stone walls etc. #0639219. 203-808-0816

**KONSTANDING MASONRY** Stone pavers, steps, Patios, Chimney, repairs & more. Call 203-528-8294

**PAUL'S MASONRY**
Stone, brick, block, walks, chimneys, patios, FP's, etc. free est. #624168. 203-706-9281

## Moving

**DON'S * MOVING**
**203-509-1488 * 203-272-3032**

## Painting

**ARMEND'S PAINTING LLC**
Int/ext carpentry low prices! Free est. CT#0631318. 203-597-7179

**ASHLEY'S PAINTING** LLC Interior & exterior. Call for estimate. 860-331-5308 Hic# 0642743

**PAUL DEVINO PAINTING** CO. LLC 1-2-3 fam. houses. Factories, shop, plaza, hotels, condos, schools, offices, church, low price free est lic 627846. 203-509-4488

**ROCCO's PAINTING**
Res. Free est & cleanup. CT# 561112. 30+ yrs exp **203-574-1906**

## Plumbing

**CAPINERA PLUMBING & HEATING**
Gas pipe, boilers HW heaters, & repairs #202962. 203-575-1551

**CHRIS SHEPPARD PLUMBING** repair, wtr heater, lawn hose bibs, gas, #283570 203-305-0072

## Power washing

**AFFORDABLE POWER WASH**
Our trucks carry water. Free est. Ins. & CT Lic# 574575. 203-597-7075

## Power washing

**ARCOM SERVICES LLC** Veteran Owned/Operated. Free est. Ins. CT Lic#0645035; 203-519-0265

**BAY KLEEN POWERWASHING** homes, decks, boats, mobile homes 203-525-3890. #0643703

## Roofing

**DIDONATO ROOFING** Remodeling & Siding. Reasonable rates. Sr. discount. #563098. **203-509-2773**

**DIDONATO ROOFING** Remodeling & Siding. Reasonable rates. Sr. discount. #563098. **203-509-2773**

**GAF ROOFING** remodeling & siding. Lowest price, ins. free est Lic. 0644170. 203-759-8665

**Lema Construction** Roofing, Siding, Gutters clean, & Chimney repair, Lic#636570. **203-510-3830**

**Michaelangelo's Roofing, LLC**
HONEST prices. No add'l fees ever. Work guaranteed. New Roofs, repairs, Chimney flashing. Respectful local owner & crew Lic. #601480-Call 203-704-1223

**PREMIER SERVICES LLC** roofing, decks, Siding, windows. Fully ins Free est #0641592. 203-228-3750

**S&S Roofing** Quality work, at a sensible price. A+ Rated BBB. Lic#573533. Steve Biff Saunders, Veteran Owned. 860-283-8590.

## Tree care

**A A A** HOME TREE REMOVAL
Lowest Price, 20 yrs exp., sr disc., free est. Fully ins'd 860-249-3094

**ALL SEASONS TREE REMOVAL**
Bucket & chip. serv. 24hr strm dam. Est, Ins'd. 860-945-0001

**ED THE TREE MAN LLC**
Large Takedown Specialist, 75' Bucket truck, Stump grinding, Tree Fertilization & Pesticide Management. Chipper & 24 Hr Emergency Serv-Firewood CT Lic. Arborist #S-5765 Bus. Reg: B-2358
**Free Est./Ins. (203) 758-0261**

**GM2 TREE SERVICES**
60' bucket truck & climbing, 24 hr. service. #0630169. 203-942-6351

**LOG DOGS COMPLETE TREE SERVICE** Lot clearing. Free est. 203-271-3355. 5% of every job donated to local dog rescue. www.logdogstreeremoval.com

**P.F.D. LLC**
Bucket truck service & climbing, tree remov., chipper, stump grinding, 24 hr serv., Sr. Disc. #618879. Free Est. **860-274-5094**

## Wood refinishing /chair repair

**KITCHEN CABINETS RESTORED**
Furn. wobbly chairs, loose & broken posts #563142 203-754-1092

**INCREASE BUSINESS! SAVE DOLLARS!**
**Run Your Ad for 28 Days & $AVE When You Prepay!**
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**Call for details 203-574-3616**
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PUBLIC NOTICE OF INTENTION NOT TO PREPARE AN ENVIRONMENTAL IMPACT EVALUATION

A. PROJECT IDENTIFICATION
Project Name: Town of Salisbury, Preliminary Engineering Report I/I and Biological Nutrient Removal Water Pollution Control Facilities

Project Location: Lakeville and Salisbury Village Sewered Areas, Salisbury WPCF located at the end of Walton Street in the Village of Lakeville

1. Project Description:

The Town of Salisbury is proposing sanitary sewer rehabilitation and WPCF improvements to address the excessive infiltration and inflow (I/I) entering the old sanitary sewers and manholes, and achieve phosphorus reductions in the treated effluent wastewater in order to meet current and future NPDES permit limits. The existing wastewater collection and treatment system provides sanitary sewer service to both the villages of Salisbury and Lakeville. Although the town has not experienced significant population growth, many of the existing sanitary sewers and manholes located in the Village of Lakeville, which date back to the early 1900's, continue to age considerably and the regulatory environment has changed with respect to phosphorus reductions. I/I has been identified as a significant problem primarily in the Lakeville Village area. It is anticipated that through this effort, the town will be able to reduce sources of excessive I/I through proposed sanitary sewer rehabilitation by means of cleaning and lining of older existing sanitary sewers and the restoration of sanitary manholes. The elimination of excessive I/I along with the proposed WPCF improvements will also further reduce phosphorus concentrations through the implementation of a chemical feed system that will achieve reductions in the total phosphorus concentrations in the treated effluent. Proposed upgrades will not result in a footprint expansion of the sewer lines or an increase in hydraulic capacity of the WPCF.

2. General Information:

The Commissioner of Energy and Environmental Protection is required to ensure that the requirements of the Connecticut Environmental Policy Act (Section 22a-1 of the Connecticut General Statues, CGS) have been met pursuant to CGS Section 22a-482 and regulations adopted thereunder. Based upon the limited nature of this project, and the environmental benefits to be realized, staff has recommended that preparation of an Environmental Impact Evaluation is not warranted.

In accordance with Sec. 22a-482-3(a)(4)(A) of the Regulations of Connecticut State Agencies, this notice of intent not to prepare an Environmental Impact Evaluation is being published. Interested persons who wish to submit comments and/or obtain more information, including inspection of supporting documentation may do so by contacting Max Fan, between the hours of 8:00 a.m. and 3:30 p.m., Monday through Friday at (860) 424-3670. Written comments will be accepted for 30 days from the publication date and should be sent to the attention of the above contact person, Bureau of Water Protection and Land Reuse, Department of Energy and Environmental Protection, 79 Elm Street, Hartford, CT 06106-5127.

/s/Betsey Wingfield, Bureau Chief
Bureau of Water Protection and Land Reuse
Dated: 4/19/2016
R-A April 20, 2016

## Greer, Leslie

**From:** Schaeffer-Helmecki, Jessica
**Sent:** Friday, April 22, 2016 11:22 AM
**To:** Hartley, Christopher; 'banthony@stmh.org'
**Cc:** Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA
**Subject:** 15-32045-CON Request for Prefile Testimony
**Attachments:** 15-32045 Saint Mary Issues & Request for Pre-File.pdf

Dear Mr. Hartley and Mr. Anthony,

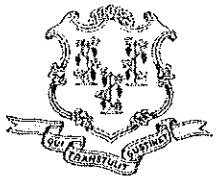
Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for May 9, 2016 (docket number 15-32045). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by May 3, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me if you have any questions.

Thank you and have a good weekend.

**Jessica Schaeffer-Helmecki, JD, MPA**
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

April 22, 2016

Via Email Only

Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
chartley@stfranciscare.org

Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.
Banthony@stmh.org

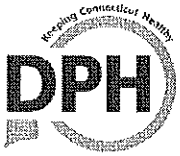
RE: Certificate of Need Application, Docket Number 15-32045
Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

Dear Mr. Hartley and Mr. Anthony,

The Office of Health Care Access ("OHCA") will, as applicants and the public have been notified previously, hold a public hearing on the above docket number on May 9, 2016. The hearing will be at 3 p.m. at Courtyard by Marriott, 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 requests that Trinity Health – New England, Inc. and Saint Mary's Hospital, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on **May 3, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **May 3, 2016**.

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410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
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Please contact Ron Ciesones or Jessica Schaeffer-Helmecki at (860) 509-8075 if you have any questions concerning this request.

Sincerely,

Kevin Hansted
Hearing Officer
Attachment

## ISSUES

### *Office of Health Care Access Docket Number: 15-32045-CON*

**The Applicants should be prepared to present and discuss supporting evidence on the following issues and others:**

1. The commitment of at least a $100 million (and potentially up to $120 million) for capital investments to benefit Saint Mary's over a 5 year period and the financial feasibility of the proposal.

2. The development of a plan to adequately fund Saint Mary's pension liabilities.

3. The status of Saint Mary's debt and the guidelines and criteria of the Trinity Health System debt program process for accessing funds.

4. Measures Trinity Health will take to meet the demands of the Patient Protection and Affordable Care Act.

5. Plans to develop preventative care services identified in Waterbury's 2014 Community Health Needs Assessment, including mental health and substance abuse, obesity and tobacco usage.

**Provide a written response to the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the application/completeness:**

1. Explain the distinction between Trinity Health – New England ("THNE") and the New England Regional Health Ministry, as both titles are used throughout the application to describe the entity proposing to acquire Saint Mary's.

2. Provide separate forms for year- to-date (YTD) actual results through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE. Use the same categories as those provided on Financial Attachment A of the original application.

3. Provide separate YTD Financial Measurement Indicators through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE in the same format as previously submitted on pages 445 and 446 of the application which includes amounts for the prior year time period (April 2015.)

4. The hospital indicated in previous correspondence that the THNE intercompany system fees are expected to be .80% of operating expenses and have not been included in the most recent financial projections submitted to OHCA. It seems that these fees will eliminate all of the proposal's projected incremental cost savings. Provide clarification on how the intercompany

fees will affect the financial performance results of Saint Mary's Hospital if the application is approved. Revised Attachment A's should be submitted for clarification purposes.

5. Regarding the $275 million capital commitment of Trinity that was referenced in CON #15-31979, complete the chart below to show a breakdown of how much of the $275 million is expected to be committed to each of the individual hospitals / health systems at the current time and if Saint Mary's attains the 8% cash flow margin and additional capital allocations in years 4 and 5 of the proposal. Previously submitted responses in this application indicate that the $100 million commitment for Saint Mary's is part of the $275 million commitment given to THNE by Trinity Health Corporation. Clarify the capital commitment for each hospital.

| Trinity Health New England – Affiliated Hospitals | Capital Commitment (current) | Capital Commitment If Saint Mary's attains 8% cash flow margin |
|---|---|---|
| Saint Mary's | $ | $ |
| Johnson Memorial | $ | $ |
| St. Francis Hospital | $ | $ |
| Total | $ | $ |

6. For each of the hospitals that are either currently part of THNE or pending approval, provide the expected source of funding for the capital commitment for each of the hospitals/systems in the table provided below:

| Source of Funding | Saint Mary's | Johnson | St. Francis |
|---|---|---|---|
| Routine Capital Expenditures | $ | $ | $ |
| Operating/Non-Operating Income | $ | $ | $ |
| Capital Contribution-Trinity | $ | $ | $ |
| Other | $ | $ | $ |

## Greer, Leslie

**From:** Hartley, Christopher <CHartley@stfranciscare.org>
**Sent:** Friday, April 22, 2016 11:41 AM
**To:** Schaeffer-Helmecki, Jessica; 'banthony@stmh.org'
**Cc:** Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA; Rotavera, Liz; Joe Connolly (JConnolly@Stmh.org); Attorney Bob Anthony (BAnthony@Stmh.org)
**Subject:** RE: 15-32045-CON Request for Prefile Testimony

Thank you

---

**From:** Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
**Sent:** Friday, April 22, 2016 11:22 AM
**To:** Hartley, Christopher; 'banthony@stmh.org'
**Cc:** Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David; User, OHCA
**Subject:** 15-32045-CON Request for Prefile Testimony

Dear Mr. Hartley and Mr. Anthony,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for May 9, 2016 (docket number 15-32045). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by May 3, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me if you have any questions.

Thank you and have a good weekend.

**Jessica Schaeffer-Helmecki, JD, MPA**
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

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## User, OHCA

| | |
|---|---|
| **From:** | Schaeffer-Helmecki, Jessica |
| **Sent:** | Wednesday, April 27, 2016 8:20 AM |
| **To:** | Hartley, Christopher; 'banthony@stmh.org' |
| **Cc:** | Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David |
| **Subject:** | 15-32045-CON Order of Admin Notice |
| **Attachments:** | 15-32045 Admin Notice.pdf |

Good Morning Mr. Hartley and Mr. Anthony,

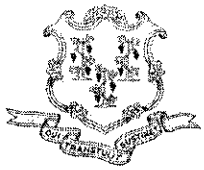
Attached please find an Order of Administrative Notice issued by Hearing Officer Hansted pertaining to the upcoming hearing associated with Docket Number 15-32045.

Please feel free to contact me if you have any questions.

Thank you,

**Jessica Schaeffer-Helmecki, JD, MPA**
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075 | F: (860) 418-7053 | E: jessica.schaeffer-helmecki@ct.gov

# STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

*Office of Health Care Access*

**Docket No: 15-32045-CON**

April 27, 2016

**In re: Saint Mary's Health System and Trinity Health – New England, Inc.**

**ORDER REGARDING ADMINISTRATIVE NOTICE**

The Office of Health Care Access, for purposes of analyzing and rendering a decision in the application filed under Docket Number 15-32045-CON, is hereby taking administrative notice of:

a) ***In re Saint Francis Care, Inc. and Trinity Health Corporation, Inc.***, Docket No. 15-31979-CON:
   - Exhibit D, Completeness Responses, pp. 635-37
   - Exhibit J, Prefiled Testimony, p. 789
   - Exhibit M, Hearing Transcript, pp. 23-35, and

b) ***In re Johnson Memorial Medical Center and Trinity Health New England.***, Docket No. 15-32002-CON:
   - Exhibit A, CON Application, pp. 24, 71
   - Exhibit D, Completeness Responses, p. 1974

*Kevin Hansted*

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Phone: (860) 418-7001• Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

## Greer, Leslie

**From:** Attorney Bob Anthony <BAnthony@Stmh.org>
**Sent:** Wednesday, April 27, 2016 10:36 AM
**To:** Schaeffer-Helmecki, Jessica; Hartley, Christopher
**Cc:** Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
**Subject:** RE: 15-32045-CON Order of Admin Notice

Thank you.

Bob Anthony

---

**From:** Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
**Sent:** Wednesday, April 27, 2016 8:20 AM
**To:** Hartley, Christopher; Attorney Bob Anthony
**Cc:** Greer, Leslie; User, OHCA; Hansted, Kevin; Riggott, Kaila; Ciesones, Ron; Fernandes, David
**Subject:** 15-32045-CON Order of Admin Notice

Good Morning Mr. Hartley and Mr. Anthony,

Attached please find an Order of Administrative Notice issued by Hearing Officer Hansted pertaining to the upcoming hearing associated with Docket Number 15-32045.

Please feel free to contact me if you have any questions.

Thank you,

**Jessica Schaeffer-Helmecki, JD, MPA**
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

Saint Mary's Health System Disclaimer:

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Saint Mary's
HOSPITAL

May 3, 2016

Via Email and Hand Delivery

Jessica Schaeffer – Helmecki, JD, MPA
Planning Analyst
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Responses to Interrogatories and Pre-File Testimonies for the Certificate of Need Application for Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc. DN: 15-32045-CON

Dear Ms. Schaeffer- Helmecki:

Enclosed please find our responses to OHCA's April 22, 2016 letter regarding the above-referenced Certificate of Need application in both pdf and word formats submitted via email and one copy hand delivered.

If you have any questions regarding this response, please do not hesitate to call Chris Hartley, Senior Vice President, Planning, Business Development and Government Relations at 860-714-5573 or Bob Anthony, General Counsel at 203-709-6447.

Sincerely,

By: _____
R. Christopher Hartley
Senior Vice President Planning
Business Development & Government Relations
Saint Francis Hospital and Medical Center

By: _____
Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.

Enclosures

Office of Health Care Access

April 22, 2016

Via Email Only

Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
chartley@stfranciscare.org

Robert Anthony
General Counsel
Saint Mary's Hospital, Inc.
Banthony@stmh.org

RE: Certificate of Need Application, Docket Number 15-32045
Transfer of Ownership of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc.

Dear Mr. Hartley and Mr. Anthony,

The Office of Health Care Access ("OHCA") will, as applicants and the public have been notified previously, hold a public hearing on the above docket number on May 9, 2016. The hearing will be at 3 p.m. at Courtyard by Marriott, 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 requests that Trinity Health – New England, Inc. and Saint Mary's Hospital, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on **May 3, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **May 3, 2016**.

Phone: (860) 418-7001 • Fax: (860) 418-7053
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Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

Please contact Ron Ciesones or Jessica Schaeffer-Helmecki at (860) 509-8075 if you have any questions concerning this request.

Sincerely,

Kevin Hansted
Hearing Officer
Attachment

## ISSUES

### *Office of Health Care Access Docket Number: 15-32045-CON*

**The Applicants should be prepared to present and discuss supporting evidence on the following issues and others:**

1. **The commitment of at least a $100 million (and potentially up to $120 million) for capital investments to benefit Saint Mary's over a 5 year period and the financial feasibility of the proposal.**

   As noted on page 865 of the application, Trinity Health and Trinity Health – New England, Inc. will commit to ensure the expenditure of up to $100 million in Capital Expenditures to support the operations and strategic initiatives of Saint Mary's Hospital and Saint Mary's controlled subsidiaries. While a significant portion of the Capital Expenditures are anticipated to be for facilities, equipment and information technology as discussed on page 869 of the application, a portion of this commitment may be available to support strategic growth and enhancement of healthcare services to better serve the community within the Waterbury area.

   In terms of the financial feasibility of the proposal, cash flow from operations for Saint Francis and its controlled subsidiaries was $33.6 million for the last 12 month ended March 31, 2016. In addition, Saint Mary's and its controlled subsidiaries had cash flow from operations for the same period of$11.8 million. Based the Saint Mary's financial projections noted in Financial Worksheet A, Saint Mary's and it's controlled subsidiaries are expected to have positive cash flow from operations (less annual debt service payments) of $13.3, $15.6 and $18.1 million for the years ended September 30, 2016, 2017 and 2018. Based on the projected cash flow margins for the two organizations, it is anticipated that a portion of the funding for the capital commitment will be available from operations and any shortfall will be available through the Trinity Health debt program through Trinity Health –New England, Inc. (refer to Table in question #6 below). Also, see list of sources of funding at page 866 question #7. Lastly, Trinity Health's strong credit rating as noted on page 871, question #14, will allow continued access to capital for strategic investments which are aligned with the strategic plan.

2. **The development of a plan to adequately fund Saint Mary's pension liabilities.**

   As noted on page 870 of the application, Saint Mary's pension plan is currently underfunded and its funding status as of September 30, 2015 was 48%. Trinity Health's funded status for its defined benefit plans was 85% as of June 30, 2015. As noted on page 83 of the original application, the applicants will develop a plan to ensure Saint Mary's ability to make annual pension payments to the plan beneficiaries.

3. **The status of Saint Mary's debt and the guidelines and criteria of the Trinity Health System debt program process for accessing funds.**

In March 2015, Saint Mary's obtained a $15.0 million bank loan. The bank loan has a five year term with $250,000 principal due each month and corresponding interest at the current LIBOR rate plus 110 basis points. The loan matures in February 2020. Saint Mary's is required to comply with certain financial covenants including a debt service coverage ratio of 1:25. It is expected that Trinity Health and Trinity Health – New England, Inc. would refinance Saint Mary's external debt with an inter-company loan post-closing. This is advantageous to Saint Mary's as it would eliminate current required debt covenant compliance at the local level.

See **Exhibit A** attached for description of Trinity Health's intercompany loan program and the process for accessing funds.

4. **Measures Trinity Health will take to meet the demands of the Patient Protection and Affordable Care Act.**

As stated on Page 22 of the application, joining Trinity Health-New England, Inc. will assist Saint Mary's in addressing the various demands created by the 2010 Patient Protection and Affordable Care Act (PPACA) including:

- Identification and development of new models of providing care
- The increased cost associated with quality improvements
- Physician partnerships
- Clinical service redesign
- Electronic medical records development
- Strategic alignments to form an integrated organization
- Meeting the needs of aging infrastructure and addressing the health service needs of the Waterbury community as identified in the Community Needs Assessment (see pages 189-261).

**New Models of Providing Care**

As noted on Page 622 of the application ". . . Trinity Health is intently focused on the delivery of high value Triple Aim outcomes that improve the health of those it serves, reduce the per capita cost of delivery care, and improve the quality of care and satisfaction of our patients . . . "Trinity Health's people-centered 2020 strategy is focused on its population health journey to improve the health of its communities and the experience of care for patients. Trinity Health's strategy is to build a people-centered health system in which the people it serves are placed at the center of every behavior, action and decision in the Trinity Health system.

Ultimately, the patients and their families who use Saint Mary's Health System, Inc., including Saint Mary's Hospital, will be able to move among the Trinity Health New England, Inc.'s facilities using a single medical record and be treated by a group of physicians and other health professionals that use a common set of clinical protocols. The goal of Trinity Health-New England, Inc. is to meet the Triple Aim objectives for each person's care. The goal would be for Trinity-Health-New England, Inc. will sign contracts with insurance programs covering the cost of care of these patients that will be based on per capita payment structures that support using the best site for individual care delivery once they exist. Trinity Health's group purchasing power, access to needed capital and the overall credit strength of Trinity Health will support the necessary changes needed to implement these new models of care for all parts of Trinity Health-New England including Saint Mary's Hospital and Health System.

**Increased Cost Associated with Quality Improvements**

Pages 622-624 of the application describe Trinity Health's ". . . Unified Clinical Organization (UCO) which provides a data and evidenced-based infrastructure for clinicians across the Trinity Health system to advance a culture of safety and high reliability . . . " led by clinicians, the UCO has promoted a wide range of system wide safety initiatives (see Page 623) which will be incorporated by Saint Mary's clinicians in their future patient interactions.

Saint Mary's clinicians will also participate in Trinity Health sponsored clinical conferences that feature recognized industry leading professionals and focus on proven methods to reduce costs, improve safety and quality. Access to this type of quality enhancement system would be too costly for a single hospital or system to provide its clinical staff on a routine basis.

In addition, as noted on Pages 262-282 on the application, Trinity Health-New England, Inc. has formed a series of clinical service lines which have a proven track record of success in the areas of quality and service excellence. Saint Mary's Hospital and Health System will become a vital member of these service lines as part of Trinity Health-New England, Inc.

**Physician Partnerships**

First and foremost, physicians are attracted to organizations that place the care of the patient first and are dedicated to meeting the highest standards of health care delivery. The commitment to quality care for patients by both Trinity Health and Trinity Health-New England, Inc. has been described previously. Both organizations will also address the new era of risk/value based contracts represented by the changes initiated by the PPACA, while still supporting the long standing commitment of Saint Mary's to education of physicians and other allied health professionals, a critical need for a state with an aging group of health care providers to match the aging of its population.

Furthermore, the scale of both Trinity Health and Trinity Health-New England, Inc. provide a recruiting infrastructure for health professionals and access to clinical collaboration that is second to none in the region and the country as a whole.

**Clinical Service Redesign**

Though covered previously, both Trinity Health UCO and Trinity Health-New England, Inc.'s Institute for Primary Care Innovation demonstrates both organizations' commitment to encourage innovation and the development and application of the latest clinical techniques to the treatment of patients. The purpose of clinical service readiness is to provide the right care in the right place at the right time. The population based approach to care management supported by Trinity Health seeks to keep people healthy and use an outpatient based approach whenever appropriate for care delivery.

**Strategic Alignments to Form an Integrated Organization**

As stated on Page 20 of the application ". . . Trinity Health has created an internal development team, charged with growth and strategic positioning of the system. Two of Trinity Health's key growth initiatives aim to extend and strengthen the Catholic healthcare mission of the organization through alignment with other organizations and to expand the system footprint to create an integrated accountable care organization (ACO) in every one of its mandates . . . "

Saint Mary's believes entering into a partnership with Trinity Health-New England, Inc. will join its organization to a strong regional Catholic system that already had an ACO and an electronic medical record as well as an established affiliation relationship with substantial post-acute care group of providers. This approach will be duplicated in the Waterbury market.

Trinity Health has indicated its willingness to support the strategic capital investment required by Trinity Health-New England, Inc. to support the strategic alignment needs of Saint Mary's Hospital and Health

**Meeting the Needs of an Aging Infrastructure and the Need to Provide the Health Services the Community of Waterbury Requires, as Reflected in the Community Needs Assessment**.

Pages 21-22, 31, 47, 82, 869 & 870 of the application make reference to the need for facility improvements, acquisition of new and replacement equipment and the purchase of a new electronic medical record. There is a 5 year capital need identified that includes:

| | $ in Millions |
|---|---|
| • Hospital facility upgrades -<br>– Primary backup generators<br>– Electric power switching gears<br>– 2 chillers<br>– 3 elevators and several air handling units | $30 |

| | |
|---|---|
| – Nursing unit upgrades<br>– Upgrades and renovations | |
| • Replacement of clinical equipment –<br>– Operating room refurbishing<br>– Upgraded breast imaging equipment<br>– Private patient room conversion | $18 |
| • Information technology upgrades and electronic health record | $12 |
| • Urgent Care/ambulatory Care | $10 |
| • Ambulatory pavilion on campus - | $25 |
| • Clinically integrated network development | $5 |
| Total | $100 |

These categories add up to $100 million. Once Saint Mary's Hospital & Health System becomes part of Trinity Health-New England, Inc., additional detail will be developed as part of the Trinity Health annual capital expenditure budget designed to address these capital needs. As identified on Page 867 projects in excess of $5 million and $25 million must be approved by Trinity Health before Saint Mary's can spend the funds. Both Trinity Health and Trinity Health-New England will bring corporate resources in purchasing, construction planning and design and the financing of individual projects as needed. The approved capital expenditures will be part of the $100 million capital planned for Saint Mary's. Capital projects from the approved capital list will be identified and implemented in each fiscal year over the 5 year period. In some cases, projects that require multiple years will be identified within each annual capital budget cycle.

For more details on capital commitment for Saint Mary's and the rest of Trinity Health-New England, please refer to Question #s 5 & 6 of this document. With regard to the Waterbury Community Needs Assessment please refer to the answer to Issue #5 of this document.

5. **Plans to develop preventative care services identified in Waterbury's 2014 Community Health Needs Assessment, including mental health and substance abuse, obesity and tobacco usage.**

On pages 189-261 (Exhibit 6) of the CON application contains the Community Needs Assessment for Waterbury completed by the Greater Waterbury Health Improvement Partnership ("GWHIP").

This Plan outlines key health statistics for the Waterbury area and identifies the challenges to keeping the population healthy. Mental health and substance abuse, obesity and tobacco usage were ranked very high in this report, and were used as the basis for organizing the work groups of the partnership.

Saint Mary's continues to play an active role in the Greater Waterbury Health Improvement Partnership (GWHIP). We have funded activities of the partnership, and play an active role in the steering committee. In addition to the work plans contained in the original document, several areas of focus have been identified. These include:

- Establishing a committee focused on asthma, with the express purpose of coordinating the activities of existing community programs such as Putting on AIRS and Easy Breathing. The formation of this workgroup is in consistent with Saint Mary's participation in the Connecticut Hospital Association's Asthma initiative. According to their website, "The goals of CHA's Statewide Asthma Initiative are to improve access and appropriate care by partnering with the community; reduce asthma hospitalizations and ED visits; and significantly advance progress toward health equity for asthma care and outcomes by 2017." Saint Mary's is an active participant in these activities.
- Supporting the formation of a Community Care Team (CCT) as part of our focus on improving mental health and substance abuse services. The CCT is a model that has been successfully implemented in other cities throughout the state. The Waterbury program, as proposed, will be financially supported through GWHIP partners and will employ a coordinator to provide administrative support for various providers to actively case manage high-frequency emergency department patients.
- Maintaining our focus on obesity, with an emphasis on establishing Healthy Corner Stores. This initiative is focused on making healthy food options available in low-income neighborhoods that have been designated as "food deserts."
- Establish a marketing and communications workgroup to more effectively communicate the resources available within our community.

By becoming a member of Trinity Health – New England, Inc. Saint Mary's will be able to strengthen its already considerable commitment to community health and preventative care services. As stated in the CON, Trinity's "Healthy People 2020" initiative is in alignment with and compliments Saint Mary's current efforts in community health initiatives.

With regard to unmet health needs, Trinity Health has a national initiative known as the "Community Health and Well-Being" strategy that focuses on three major health goals:

Goal 1: Reduce the number of people who are uninsured in our communities.

Goal 2: Prioritize obesity prevention and tobacco control and;

Goal 3: Transform safety net care

These system wide goals have deliverables that are specific, measurable, attainable, relevant and time bonded and all Regional Health Ministries are participants in achieving these goals.

**Goal 1 Objective - In partnership with community organizations each regional health ministry (RHM) will host or co-lead 10 enrollment activities targeted at reaching a total of 5% of the eligible population in the RHM's market.**

In an effort to achieve this objective each RHM is an active participant in the annual open enrollment efforts of each State Health Exchange.

**Goal 2 Objective – Develop a tobacco and obesity prevention portfolio**

This portfolio is aimed at supporting healthy choices in RHM communities including tobacco free living, physical activity and healthy eating.

This support includes forming community coalitions and changing institutional policies where necessary to ensure greater support for healthy communities. One example of the steps being taken in this area include Trinity Health's national and state efforts to move the legal minimum age for cigarette purchases to 21 (Tobacco 21).

**Goal 3 Objective- Seeks to improve the health of seniors 65 years and older who are dually eligible for Medicare and Medicaid**

The dually eligible elderly represent some of the poorest and sickest individuals. Working with Trinity Health each RHM will develop best care practices and innovations aimed at encouraging alternate care models and/or risk contracting initiatives focused on this population. Whenever possible these initiatives will include external partners from the community.

To support this initiative all members of Trinity Health have access to Trinity Health's central office resources including:

- A Data Mart containing a large array of data from many sources addressing needs and services used by dually eligible elderly.
- Summary of promising best practices for clinical integration.
- Turn key delivery tool kits.

Clearly by becoming a part of Trinity Health - New England Inc., a great deal of additional resources will be available to Saint Mary's in its efforts to improve health of the Waterbury community.

In addition to these Trinity Health system wide initiatives Saint Mary' s will also be integrated with the health needs strategies identified by Trinity Health – New England, Inc. through its own 2016 Community Needs Assessment (CHNA) and Strategic Implementation Plan (SIP). At present this CHNA is scheduled for completion on 6/30/16 and the SIP on 11/15/16. Once Saint Mary's Hospital and Health System joins Trinity Health - New England, Inc. its Data Haven survey

data will be reviewed and the priorities of the Trinity Health - New England, Inc. Strategic Implementation Plan will be adjusted to reflect this data where necessary.

**Provide a written response to the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the application/completeness:**

1. **Explain the distinction between Trinity Health – New England ("THNE") and the New England Regional Health Ministry, as both titles are used throughout the application to describe the entity proposing to acquire Saint Mary's.**

   There is no distinction between Trinity Health-New England, Inc. (the formal legal name registered with the Connecticut Secretary of State) and the New England Regional Health Ministry (the abbreviated reference to the legal entity).

2. **Provide separate forms for year- to-date (YTD) actual results through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE. Use the same categories as those provided on Financial Attachment A of the original application.**

   See **Exhibit B** (note due to timing, YTD actual results were provided through March 31, 2016)

3. **Provide separate YTD Financial Measurement Indicators through April 2016 for Saint Mary's Health System, Saint Mary's Hospital and THNE in the same format as previously submitted on pages 445 and 446 of the application which includes amounts for the prior year time period (April 2015.)**

   See **Exhibit C** (note due to timing, YTD Financial Measurement Indicators were provided through March 31, 2016)

4. **The hospital indicated in previous correspondence that the THNE intercompany system fees are expected to be .80% of operating expenses and have not been included in the most recent financial projections submitted to OHCA. It seems that these fees will eliminate all of the proposal's projected incremental cost savings. Provide clarification on how the intercompany fees will affect the financial performance results of Saint Mary's Hospital if the application is approved. Revised Attachment A's should be submitted for clarification purposes.**

   As noted on page 1016 of the certificate of need application, the system office allocation is at the Regional Health Ministry level. Therefore, Trinity Health – New England will be charged these system office fees. Trinity Health – New England will then allocate the system fees to each organization within the regional health ministry based on at least two factors ( size of the

organization and the status of utilization of system resources). The utilization of system office resources and further integration among the hospitals within Trinity Health – New England, Inc. should ultimately decrease local expenses. For example, if external audit and consulting firms are being utilized to prepare tax returns and other analysis, the system office resources including the tax department and internal consultants will be available to provide these services. Furthermore, as noted on page 1016, it is expected that the system office allocation will decrease as Trinity Health – New England, Inc. become more efficient through integration across the various hospital/systems.

5. **Regarding the $275 million capital commitment of Trinity that was referenced in CON #15-31979, complete the chart below to show a breakdown of how much of the $275 million is expected to be committed to each of the individual hospitals / health systems at the current time and if Saint Mary's attains the 8% cash flow margin and additional capital allocations in years 4 and 5 of the proposal. Previously submitted responses in this application indicate that the $100 million commitment for Saint Mary's is part of the $275 million commitment given to THNE by Trinity Health Corporation. Clarify the capital commitment for each hospital.**

| Trinity Health New England – Affiliated Hospitals | Capital Commitment (current) | Capital Commitment If Saint Mary's attains 8% cash flow margin |
|---|---|---|
| Saint Mary's | $100 million | $120 million |
| Johnson Memorial | $ 13 million | $13 million |
| St. Francis Hospital | $162 million | $142 million |
| Total | $275 million | $275 million |

As previously noted, this is the **minimum** capital commitment for each of the respective organizations and their affiliated entities. In addition, the allocation of the $275 million Capital Commitment as noted on page 1017 of the original CON and on page 635 of the Saint Francis CON will be based on strategic priorities of the collective organizations. "The capital expenditure commitment made to Saint Francis *Care* will be available to support the capital needs of Saint Francis *Care*, including for the strategic growth and infrastructure development of the new RHM's integrated delivery system, the expansion and upgrade of the health care services provided by the new RHM, the support of community health/population management initiatives, and for strategic growth including potential mergers, acquisitions, joint ventures and physician network development."

6. **For each of the hospitals that are either currently part of THNE or pending approval, provide the expected source of funding for the capital commitment for each of the hospitals/systems in the table provided below:**

| Source of Funding | Saint Mary's | Johnson | Saint. Francis |
|---|---|---|---|
| Total Capital Expenditures (Capital Commitment) | $100.0 million | $13.0 million | $162.0 million |
| Operating Income (Minimum from operations for capital is to fund annual deprecation)[1] | $45.3 | $5.6 | $158.0 |
| Trinity Health (intercompany loan and/or capital contribution) | $54.7 | $7.4 | $ 4.0 |
| Other | $n/a | $n/a | $n/a |

As noted in the response to question #1 above, the goal of Trinity Health – New England is to fund the $275 million total Capital Commitment for the region through cash flow from operations. The preliminary budget for FY 2017 for the Saint Francis system includes a cash flow margin of $49.6 million. However, due to continued uncertainty with respect to the state supplemental payment for Hospitals for FY 2017, many Connecticut hospitals, including Saint Francis will have to obtain significant cost reductions in order to achieve this level of cash flow margin. Therefore, if such target is not achieved, the allocation necessary from Trinity Health may increase. As noted on page 866 of the Saint Mary's CON application, the sources of funding are available cash and investments generated by each of the Hospital/Systems; financing available through Trinity Health system debt program and capital contributions from Trinity Health. The allocation by source of funding is preliminary based on current operating performance and could change based on future operating cash flows.

As noted in the response to question #1 above, the goal of each of the hospitals/systems is to fund the majority of the capital expenditure through current operations. The preliminary budget for FY 2017 for Saint Francis system includes a cash flow margin of $49.6 million. However, due to continued uncertainty with respect to the state supplemental payment for Hospitals for FY 2017, many Connecticut hospitals, including Saint Francis will have to obtain significant cost reductions in order to achieve this level of cash flow margin. As noted on page 866 of the Saint Mary's CON application, the sources of funding are available cash and investments generated by each of the Hospital/Systems; financing available through Trinity Health system debt program and capital contributions from Trinity Health. Further allocation of the source of funding by category by entity for these respective five year commitments are not known at this time.

[1] Estimated based on current annual depreciation less principal debt payments

# EXHIBIT A

## Exhibit A

# Trinity Health Inter-Company Loan Program (the "Program")

### Program Description

Under the Program, Trinity Health is the primary obligor on all existing tax-exempt debt issued by Trinity Health or its predecessor organizations. All tax-exempt debt is issued by Trinity Health under the Trinity Health Master Trust Indenture. Long-term debt of Regional Health Ministries (RHMs) is coordinated by Trinity Health and funded internally through loans from the Program.

### Background and Program Characteristics

- Ensures all RHMs borrow at the same rate
- Enables the financing of projects in states with the lowest all-in borrowing costs through composite bond issues, typically on an annual basis
- Maximizes the life of the debt and minimizes annual debt service requirements
- Proceeds from annual composite bond issues are used to replenish the Program fund
- Proceeds from Inter-Company Loans (ICLs) are used to:
    - Replenish cash spent on capital expenditures
    - Offset annual increase in operating expenses to maintain days cash on hand
    - Fund the amortization of debt

### Process for Issuing Inter-Company Loans

Each year during the Strategic Financial Planning process, the appropriate amount of debt and cash for each RHM is determined. This is further refined during the annual Budget process.

- The total budgeted amount to be borrowed by each RHM is calendarized and System Office Treasury provides rate and monthly interest expense schedules to include in the budget
- Treasury will receive final approved budgets which will indicate, by RHM and month, the amount to be borrowed during the fiscal year
- Per the approved budget, Treasury initiates transfers to the respective RHM operating accounts on the first business day of each month

- Treasury initiates sweep transactions for interest, principal and swap charges each month

**Standard Program Procedures**

- Calculation of Program Effective Interest Rate (the "Sweep Rate") *
  - Forecast interest rates
    - Obtain LIBOR and SIFMA rates projection from independent third party sources
    - Determine external interest expense for total indebtedness
  - Determine cost of debt administration
    - External interest expense
    - Commercial Paper fees
    - Trustee, legal and finance authorities' service fees
    - Swap settlements
  - Set rates for budget period for interest and swap payments
    - The Sweep Rate will be assessed to each participant based on their total intercompany loan balance outstanding
- Periodic Adjustments to RHM Sweep Rate (if necessary)
  - Notice of rate change to RHMs
  - Analysis of impact to operating income and budget
  - Prepare updated amortization schedules
- New ICLs
  - Develop recommendation for proposed loan via budgeting process
  - Prepare loan documentation, including RHM Promissory Note
  - Coordinate and initiate loan(s) according to budget schedule on first day of each month
- Collection of ICL Debt Service
  - Distribute updated amortization schedules
  - Initiate mid-month cash sweep
  - Coordinate accounting records
- Impact of New Bond Issues
  - Incorporate new debt into Cost of Capital schedule
  - Calculate revised budget rates

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**Includes Cost of Trinity Health Swap Program*

**Debt Refinancing and Refunding**

- In addition to the replenishment of Program funds, the annual composite bond issue also provides an opportunity to refund tax-exempt bonds
- Existing Trinity Health tax-exempt bonds are continuously monitored and analyzed to determine if there is sufficient economic benefit to refund
- In conjunction with the acquisition of a new affiliate, the entity typically enters into the Trinity Health Credit Group as a Designated Affiliate under the Trinity Health Master Trust Indenture
- To the extent allowable under existing documents, the debt of the new affiliate is defeased or redeemed through an Inter-Company Loan from the Program (the underlying bonds may be refunded through the annual composite issue or through the Trinity Health Commercial Paper Program as an interim/bridge financing until the next appropriate composite issue

# EXHIBIT B

(YTD) actual results for
Saint Mary's Health System, Saint Mary's Hospital and
TH-NE

**NON-PROFIT**

**Saint Mary's Health System, Inc.**

**Financial Worksheet (A)**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **Actual** | **YTD March** | **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 | $832,217 | $454,966 | | $454,966 | | | $0 | $0 | | $0 | $0 | | $0 |
| 2 | Less: Allowances | $535,300 | $297,452 | | $297,452 | | | $0 | $0 | | $0 | $0 | | $0 |
| 3 | Less: Charity Care | $1,854 | $855 | | $855 | | | $0 | $0 | | $0 | $0 | | $0 |
| 4 | Less: Other Deductions | $4,738 | $6,348 | | $6,348 | | | $0 | $0 | | $0 | $0 | | $0 |
| | **Net Patient Service Revenue** | **$290,325** | **$150,311** | **$0** | **$150,311** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 5 | Medicare | $111,548 | $57,719 | | $57,719 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 6 | Medicaid | $53,959 | $26,455 | | $26,455 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | CHAMPUS & TriCare | $225 | $1,052 | | $1,052 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 8 | Other | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | **Total Government** | **$165,732** | **$85,226** | **$0** | **$85,226** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 9 | Commercial Insurers | $104,937 | $55,014 | | $55,014 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Uninsured | $9,669 | $4,960 | | $4,960 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 11 | Self Pay | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 12 | Workers Compensation | $8,834 | $4,509 | | $4,509 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 13 | Other | $1,153 | $601 | | $601 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | **Total Non-Government** | **$124,593** | **$65,085** | **$0** | **$65,085** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | **$290,325** | **$150,311** | **$0** | **$150,311** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 14 | Less: Provision for Bad Debts | $9,675 | $5,798 | | **$5,798** | | | **$0** | $0 | | **$0** | $0 | | **$0** |
| | **Net Patient Service Revenue less provision for bad debts** | **$280,650** | **$144,513** | **$0** | **$144,513** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 15 | Other Operating Revenue | $9,339 | $5,288 | | **$5,288** | | | **$0** | $0 | | **$0** | $0 | | **$0** |
| 17 | Net Assets Released from Restrictions | $733 | $320 | | **$320** | | | **$0** | $0 | | **$0** | $0 | | **$0** |
| | **TOTAL OPERATING REVENUE** | **$290,722** | **$150,121** | **$0** | **$150,121** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **B.** | **OPERATING EXPENSES** | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $123,197 | $64,454 | | $64,454 | | | $0 | $0 | | $0 | $0 | | $0 |
| 2 | Fringe Benefits | $32,298 | $16,909 | | $16,909 | | | $0 | $0 | | $0 | $0 | | $0 |
| 3 | Physicians Fees | $9,915 | $5,467 | | $5,467 | | | $0 | $0 | | $0 | $0 | | $0 |
| 4 | Supplies and Drugs | $47,026 | $22,832 | | $22,832 | | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 5 | Depreciation and Amortization | $11,636 | $6,107 | | $6,107 | | | $0 | $0 | | $0 | $0 | | $0 |
| 6 | Provision for Bad Debts-Other[b] | | | | $0 | | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | Interest Expense | $980 | $128 | | $128 | | | $0 | $0 | | $0 | $0 | | $0 |
| 8 | Malpractice Insurance Cost | $5,572 | $3,343 | | $3,343 | | | $0 | $0 | | $0 | $0 | | $0 |
| 9 | Lease Expense | | | | $0 | | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Other Operating Expenses | $57,937 | $27,185 | | $27,185 | | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| | **TOTAL OPERATING EXPENSES** | **$288,561** | **$146,425** | **$0** | **$146,425** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | **INCOME/(LOSS) FROM OPERATIONS** | **$2,161** | **$3,696** | **$0** | **$3,696** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | **NON-OPERATING REVENUE** | **$2,528** | **$503** | | **$503** | | | **$0** | **$0** | | **$0** | **$0** | | **$0** |
| | **EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES** | **$4,689** | **$4,199** | **$0** | **$4,199** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | Principal Payments | **$3,000** | $1,500 | | **$1,500** | | | **$0** | | | **$0** | | | **$0** |
| **C.** | **PROFITABILITY SUMMARY** | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | **0.7%** | **2.5%** | **0.0%** | **2.5%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |

**NON-PROFIT**

**Saint Mary's Health System, Inc.**

**Financial Worksheet (A)**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **Actual** | **YTD March** | **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** |
| 2 | Hospital Non Operating Margin | **0.9%** | **0.3%** | **0.0%** | **0.3%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |
| 3 | Hospital Total Margin | **1.6%** | **2.8%** | **0.0%** | **2.8%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |
| | | | | | | | | | | | | | | |
| **D.** | **FTEs** | **1,680** | 1,691 | | **1,691** | | | **0** | | | **0** | | | **0** |
| | | | | | | | | | | | | | | |
| **E.** | **VOLUME STATISTICS[c]** | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 11,847 | 5,833 | | **5,833** | | | **0** | | | **0** | | | **0** |
| 2 | Outpatient Visits | 238,522 | 125,267 | | **125,267** | | | **0** | 0 | | **0** | 0 | | **0** |
| | **TOTAL VOLUME** | **250,369** | **131,100** | **0** | **131,100** | **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 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.

**NON-PROFIT**

**Saint Mary's Hospital (only)**

**Financial Worksheet (A)**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **Actual** | **YTD March** | **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 | $746,752 | $406,827 | | $406,827 | | | $0 | $0 | | $0 | $0 | | $0 |
| 2 | Less: Allowances | $484,797 | $268,852 | | $268,852 | | | $0 | $0 | | $0 | $0 | | $0 |
| 3 | Less: Charity Care | $1,854 | $855 | | $855 | | | $0 | $0 | | $0 | $0 | | $0 |
| 4 | Less: Other Deductions | $4,738 | $6,348 | | $6,348 | | | $0 | $0 | | $0 | $0 | | $0 |
| | **Net Patient Service Revenue** | **$255,363** | **$130,772** | **$0** | **$130,772** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 5 | Medicare | $98,115 | $50,216 | | $50,216 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 6 | Medicaid | $47,461 | $23,016 | | $23,016 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | CHAMPUS & TriCare | $198 | $915 | | $915 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 8 | Other | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | **Total Government** | **$145,774** | **$74,148** | **$0** | **$74,148** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 9 | Commercial Insurers | $92,300 | $47,863 | | $47,863 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Uninsured | $8,505 | $4,315 | | $4,315 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 11 | Self Pay | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 12 | Workers Compensation | $7,770 | $3,923 | | $3,923 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| 13 | Other | $1,014 | $523 | | $523 | $0 | | $0 | $0 | | $0 | $0 | | $0 |
| | **Total Non-Government** | **$109,589** | **$56,624** | **$0** | **$56,624** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | **$255,363** | **$130,772** | **$0** | **$130,772** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 14 | Less: Provision for Bad Debts | $8,180 | $4,961 | | **$4,961** | | | **$0** | $0 | | **$0** | $0 | | **$0** |
| | **Net Patient Service Revenue less provision for bad debts** | **$247,183** | **$125,811** | **$0** | **$125,811** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| 15 | Other Operating Revenue | $7,473 | $4,950 | | **$4,950** | | | **$0** | $0 | | **$0** | $0 | | **$0** |
| 17 | Net Assets Released from Restrictions | $733 | $320 | | **$320** | | | **$0** | $0 | | **$0** | $0 | | **$0** |
| | **TOTAL OPERATING REVENUE** | **$255,389** | **$131,081** | **$0** | **$131,081** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **B.** | **OPERATING EXPENSES** | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $88,793 | $45,110 | | $45,110 | | | $0 | $0 | | $0 | $0 | | $0 |
| 2 | Fringe Benefits | $27,562 | $14,267 | | $14,267 | | | $0 | $0 | | $0 | $0 | | $0 |
| 3 | Physicians Fees | $10,621 | $5,693 | | $5,693 | | | $0 | $0 | | $0 | $0 | | $0 |
| 4 | Supplies and Drugs | $45,059 | $21,814 | | $21,814 | | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 5 | Depreciation and Amortization | $10,805 | $5,737 | | $5,737 | | | $0 | $0 | | $0 | $0 | | $0 |
| 6 | Provision for Bad Debts-Other[b] | $0 | $0 | | $0 | | | $0 | $0 | | $0 | $0 | | $0 |
| 7 | Interest Expense | $963 | $119 | | $119 | | | $0 | $0 | | $0 | $0 | | $0 |
| 8 | Malpractice Insurance Cost | $3,802 | $2,351 | | $2,351 | | | $0 | $0 | | $0 | $0 | | $0 |
| 9 | Lease Expense | $0 | $0 | | $0 | | | $0 | $0 | | $0 | $0 | | $0 |
| 10 | Other Operating Expenses | $49,045 | $22,512 | | $22,512 | | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| | **TOTAL OPERATING EXPENSES** | **$236,650** | **$117,603** | **$0** | **$117,603** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | **INCOME/(LOSS) FROM OPERATIONS** | **$18,739** | **$13,478** | **$0** | **$13,478** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | **NON-OPERATING REVENUE** | **$2,522** | **$227** | | **$227** | | | **$0** | **$0** | | **$0** | **$0** | | **$0** |
| | **EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES** | **$21,261** | **$13,705** | **$0** | **$13,705** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| | Principal Payments | **$3,000** | $1,500 | | **$1,500** | | | **$0** | | | **$0** | | | **$0** |

**NON-PROFIT**

**Saint Mary's Hospital (only)**

**Financial Worksheet (A)**

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) | (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **LINE** | **Total Entity:** | **FY 2015** | **FY 2016** | **FY 2016** | **FY 2016** | **FY 2017** | **FY 2017** | **FY 2017** | **FY 2018** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2019** | **FY 2019** |
| | | **Actual** | **YTD March** | **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.** | **PROFITABILITY SUMMARY** | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | **7.3%** | **10.3%** | **0.0%** | **10.3%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |
| 2 | Hospital Non Operating Margin | **1.0%** | **0.2%** | **0.0%** | **0.2%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |
| 3 | Hospital Total Margin | **8.2%** | **10.4%** | **0.0%** | **10.4%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** |
| **D.** | **FTEs** | **1,384** | **1,387** | | **1,387** | | | **0** | 0 | | **0** | 0 | | **0** |
| **E.** | **VOLUME STATISTICS[c]** | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 11,847 | 5,833 | | **5,833** | | | **0** | | | **0** | | | **0** |
| 2 | Outpatient Visits | 238,522 | 125,267 | | **125,267** | | | **0** | 0 | | **0** | 0 | | **0** |
| | **TOTAL VOLUME** | **250,369** | **131,100** | **0** | **131,100** | **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 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.

**Trinity Health - New England, Inc.** **NON-PROFIT**

**Applicant:**

**Financial Worksheet (A)**

| LINE | Total Entity: | (1) FY 2016 YTD MARCH |
|---|---|---|
| | Description | |
| A. | OPERATING REVENUE | |
| 1 | Total Gross Patient Revenue | $ 1,294,926 |
| 2 | Less: Allowances | 861,377 |
| 3 | Less: Charity Care | 6,479 |
| 4 | Less: Other Deductions | 13,560 |
| | **Net Patient Service Revenue** | **$ 413,510** |
| 5 | Medicare | 160,517 |
| 6 | Medicaid | 55,304 |
| 7 | CHAMPUS & TriCare | 745 |
| 8 | Other | - |
| | **Total Government** | **$216,566** |
| 9 | Commercial Insurers | 197,920 |
| 10 | Uninsured | 7,417 |
| 11 | Self Pay | - |
| 12 | Workers Compensation | 5,168 |
| 13 | Other | - |
| | **Total Non-Government** | **$ 210,505** |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | **$ 427,071** |
| 14 | Less: Provision for Bad Debts | 11,900 |
| | **Net Patient Service Revenue less provision for bad debts** | **$ 401,610** |
| 15 | Other Operating Revenue | 19,795 |
| 17 | Net Assets Released from Restrictions | 4,035 |
| | **TOTAL OPERATING REVENUE** | **$425,440** |
| B. | OPERATING EXPENSES | |
| 1 | Salaries and Wages | $ 198,862 |
| 2 | Fringe Benefits | 48,421 |
| 3 | Physicians Fees | 14,703 |
| 4 | Supplies and Drugs | 71,607 |
| 5 | Depreciation and Amortization | 23,400 |
| 6 | Provision for Bad Debts-Other[b] | - |
| 7 | Interest Expense | 4,745 |
| 8 | Malpractice Insurance Cost | 6,193 |
| 9 | Lease Expense | 4,826 |
| 10 | Other Operating Expenses | 69,195 |
| | **TOTAL OPERATING EXPENSES** | **$ 441,952** |
| | **INCOME/(LOSS) FROM OPERATIONS** | **$ (16,512)** |
| | **NON-OPERATING REVENUE** | (3,332) |
| | **EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES** | **$ (19,844)** |
| | Principal Payments | **$3,326** |

**Trinity Health - New England, Inc.** **NON-PROFIT**

**Applicant:**

**Financial Worksheet (A)**

| LINE | Total Entity: | (1) FY 2016 YTD MARCH |
|---|---|---|
| | Description | |
| C. | PROFITABILITY SUMMARY | |
| 1 | Hospital Operating Margin | -3.9% |
| 2 | Hospital Non Operating Margin | -0.8% |
| 3 | Hospital Total Margin | -4.7% |
| D. | FTEs | 4,762.8 |
| E. | VOLUME STATISTICS[c] | |
| 1 | Inpatient Discharges | 16,345 |
| 2 | Outpatient Visits | 568,914 |
| | TOTAL VOLUME | 585,259 |

[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 related to the provision of direct services to patients. For additional information, information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

# EXHIBIT C

(YTD) financial measurements
Saint Mary's Health System, Saint Mary's Hospital and TH-NE

Saint Mary's Health System

**D. Additional Statistics (in thousands)**

| | Year to Date March 2016 | Prior Year | Explanations |
|---|---|---|---|
| Income from Operations | $ 3,696 | $ 1,819 | YTD net patient revenue increased $7.6 million due to growth in outpatient volumes. This was partially offset by increase in Hospital Tax of $3.8 million. Overall, operating expenses increased $1.9 million mostly in labor costs, offset by reductions in purchased services and medical supplies. |
| Revenue Over/(Under) Expense | $ 4,199 | $ 4,475 | The increase from operations was offset by a decrease in non operating activity associated with investment returns and joint activity. |
| EBITDA | $ 9,930 | $ 8,095 | The increase is consistent with the increase in income from operations. |
| Patient Cash Collected | $ 148,477 | $ 136,583 | The increase is associated with the increase in net revenues, along with better cash collections in current year. |
| Cash and Cash Equivalents | $ 19,016 | $ 20,017 | Cash decreased as a result of the increase in Hospital Tax payments |
| Net Working Capital | $ 25,933 | $ 36,932 | In March FY15, we took out a new loan to pay off CHEFA Bonds. The Bonds were paid off in April 2015. This increased net working capital for March 2015 by $15 million. |
| Unrestricted Assets | $ 36,778 | $ 37,095 | The decrease in unrestricted net assets is due to the increase in Hospital Tax and increase in the underfunded status of the pension plan. |
| Credit Ratings (S&P, FITCH and Moody's) | Ba2 | Ba2 | |

| | Saint Mary's Health System | Month | | Year to Date | |
|---|---|---|---|---|---|
| | | March 2016 | Prior Year | March 2016 | Prior Year |
| **A.** | **Operating Performance** | | | | |
| | Operating Margin | 6.9% | 3.2% | 2.4% | 1.2% |
| | Non-Operating Margin | -0.6% | 1.2% | 0.3% | 1.8% |
| | Total Margin | 6.4% | 4.4% | 2.7% | 3.0% |
| | Bad Debt as % of Gross Revenue | 1.3% | 1.0% | 1.3% | 1.2% |
| **B.** | **Liquidity** | | | | |
| | Current Ratio | 2.12 | 2.25 | 2.12 | 2.25 |
| | Days Cash on Hand | 24 | 26 | 24 | 26 |
| | Days in Net Accounts Receivable | 41 | 42 | 41 | 42 |
| | Average Payment Period | 58 | 57 | 58 | 57 |
| **C.** | **Leverage and Capital Structure** | | | | |
| | Long-term Debt to Equity | 0.24 | 0.63 | 0.24 | 0.63 |
| | Long-term Debt to Capitalization | 0.20 | 0.39 | 0.20 | 0.39 |
| | Unrestricted Cash to Debt | 1.44 | 0.56 | 1.44 | 0.56 |
| | Times Interest Earned Ratio | 86.4 | 10.5 | 33.87 | 7.11 |
| | Debt Service Coverage Ratio | 11.9 | 7.4 | 6.62 | 5.40 |
| | Equity Financing Ratio | 3.85 | 4.01 | 3.85 | 4.01 |
| **D.** | **Additional Statistics** | | | | |
| | Income from Operations | $ 1,967,046 | $ 801,240 | $ 3,695,680 | $ 1,819,011 |
| | Revenue Over/(Under) Expense | $ 1,806,716 | $ 1,106,507 | $ 4,198,966 | $ 4,474,726 |
| | EBITDA | $ 2,985,409 | $ 1,858,696 | $ 9,930,131 | $ 8,095,445 |
| | Patient Cash Collected | $ 28,863,325 | $ 24,057,295 | $ 148,477,112 | $ 136,583,386 |
| | Cash and Cash Equivalents | $ 19,015,875 | $ 20,017,346 | $ 19,015,875 | $ 20,017,346 |
| | Net Working Capital | $ 25,933,351 | $ 36,931,760 | $ 25,933,351 | $ 36,931,760 |
| | Unrestricted Assets | $ 36,777,596 | $ 37,095,324 | $ 36,777,596 | $ 37,095,324 |
| | Credit Ratings (S&P, FITCH and Moody's) | Ba2 | Ba2 | Ba2 | Ba2 |

Saint Mary's Hospital

**D. Additional Statistics (in thousands)**

| | Year to Date March 2016 | Prior Year | Explanations |
|---|---|---|---|
| Income from Operations | $ 13,478 | $ 9,375 | YTD net patient revenue increased $5.2 million due to growth in outpatient volumes. This was partially offset by increase in Hospital Tax of $3.8 million. Overall, operating expenses decreased $2.5 million mostly in purchased services and medical supplies. |
| Revenue Over/(Under) Expense | $ 13,705 | $ 12,443 | The increase from operations was partially offset by a decrease in non operating activity associated with investment return and income from joint ventures. |
| EBITDA | $ 19,334 | $ 15,368 | The increase is consistent with the increase in income from operations. |
| Patient Cash Collected | $ 129,772 | $ 120,161 | The increase is associated with the increase in net revenues, along with better cash collections in current year. |
| Cash and Cash Equivalents | $ 17,614 | $ 19,123 | Cash decreased as a result of increase in Hospital Tax payments |
| Net Working Capital | $ 15,067 | $ 28,338 | In March FY15, we took out a new loan to pay off CHEFA Bonds. The Bonds were paid off in April. This increased net working capital for March 2015 by $15 million. |
| Unrestricted Assets | $ 31,729 | $ 32,236 | The decrease in unrestricted net assets is due to the increase in Hospital Tax, increase in the underfunded status of the pension plan and funding to the Medical Group, offset by current year performance. |
| Credit Ratings (S&P, FITCH and Moody's) | Ba2 | Ba2 | |

| | Saint Mary's Hospital | Month | | Year to Date | |
|---|---|---|---|---|---|
| | | March 2016 | Prior Year | March 2016 | Prior Year |
| **A.** | **Operating Performance** | | | | |
| | Operating Margin | 15.4% | 7.3% | 9.8% | 7.1% |
| | Non-Operating Margin | -0.9% | 2.9% | 0.2% | 2.3% |
| | Total Margin | 14.5% | 10.1% | 10.0% | 9.4% |
| | Bad Debt as % of Gross Revenue | 1.3% | 1.2% | 1.2% | 1.2% |
| **B.** | **Liquidity** | | | | |
| | Current Ratio | 1.81 | 2.06 | 1.81 | 2.06 |
| | Days Cash on Hand | 27 | 30 | 27 | 30 |
| | Days in Net Accounts Receivable | 40 | 41 | 40 | 41 |
| | Average Payment Period | 62 | 61 | 62 | 61 |
| **C.** | **Leverage and Capital Structure** | | | | |
| | Long-term Debt to Equity | 0.25 | 0.67 | 0.25 | 0.67 |
| | Long-term Debt to Capitalization | 0.20 | 0.40 | 0.20 | 0.40 |
| | Unrestricted Cash to Debt | 1.45 | 0.55 | 1.45 | 0.55 |
| | Times Interest Earned Ratio | 183.5 | 20.5 | 115.69 | 18.17 |
| | Debt Service Coverage Ratio | 19.3 | 10.5 | 12.89 | 10.25 |
| | Equity Financing Ratio | 3.87 | 4.04 | 3.87 | 4.04 |
| **D.** | **Additional Statistics** | | | | |
| | Income from Operations | $ 3,861,301 | $ 1,608,253 | $ 13,477,741 | $ 9,374,825 |
| | Revenue Over/(Under) Expense | $ 3,643,877 | $ 2,240,864 | $ 13,704,989 | $ 12,442,790 |
| | EBITDA | $ 4,830,843 | $ 2,620,209 | $ 19,334,355 | $ 15,368,065 |
| | Patient Cash Collected | $ 25,716,325 | $ 21,143,295 | $ 129,772,112 | $ 120,161,386 |
| | Cash and Cash Equivalents | $ 17,614,289 | $ 19,123,132 | $ 17,614,289 | $ 19,123,132 |
| | Net Working Capital | $ 15,066,620 | $ 28,337,914 | $ 15,066,620 | $ 28,337,914 |
| | Unrestricted Assets | $ 31,728,979 | $ 32,235,922 | $ 31,728,979 | $ 32,235,922 |
| | Credit Ratings (S&P, FITCH and Moody's) | Ba2 | Ba2 | Ba2 | Ba2 |

# Trinity Health - New England

| Monthly Financial Measurement/Indicators | March 16 YTD | March 15 YTD | Comments |
|---|---|---|---|
| **A. Operating Performance:** | | | |
| Operating Margin | (3.9%) | 1.3% | operating income/operating revenues |
| Non-Operating Margin | NA | NA | |
| Total Margin | 2.8% | 7.6% | Operating cash flow margin (EBIDA/operating revenue) |
| Bad Debt as % of Gross Revenue | 0.9% | 1.0% | bad debt/total patient serv. Revenue(before allowances) |
| **B. Liquidity:** | | | |
| Current Ratio | 2.0 | 2.1 | current assets/current liabilites |
| Days Cash on Hand | 53.5 | 76.5 | (cash and cash equiv+board restr. cash)/(total exp-depr)/YTD days in yr |
| Days in Net Accounts Receivables | 34.5 | 38.1 | net ar/net patient ser rev/days in yr |
| Average Payment Period | 48.3 | 55.0 | current liabilities/(total exp-depr)/YTD days in yr |
| **C. Leverage and Capital Structure:** | | | |
| Long-term Debt to Equity | 149.8% | 117.3% | total debt/total equity(net assets) |
| Long-term Debt to Capitalization | 60.0% | 54.0% | LTD/LTD+net assets |
| Unrestricted Cash to Debt | 46.0 | 62.6 | (cash and cash equiv+board restr. cash)/total debt (lt & st)*100 |
| Times Interest Earned Ratio | (2.5) | 1.9 | EBIT/Interest expense |
| Debt Service Coverage Ratio | 0.9 x | 2.1 x | (Net inc+int+depr)/(st debt+int exp) |
| Equity Financing Ratio | 21.8% | 23.9% | Net assets/total assets |
| **D. Additional Statistics (in thousands)** | | | |
| Income(Loss) from Operations | $ (16,512) | $ 5,319 | Net income(loss) from operations |
| Revenue Over/(Under) Expense | $ (19,844) | $ (11,271) | Net gain(loss) |
| EBITDA | $ 11,804 | $ 30,785 | based on net income(loss) from operations |
| Patient Cash Collected | NA | NA | |
| Cash and Cash Equivalents | $ 100,142 | $ 127,634 | from cons bs |
| Net Working Capital | $ 106,041 | $ 123,695 | current assets-current liabilities |
| Unrestricted Assets | $ 93,165 | $ 125,633 | from cons bs |

CON 15-32045 Financial Statistics

Trinity Health - New England

| | March 16 YTD | March 15 YTD | Explanation |
|---|---|---|---|
| **D. Additional Statistics** | | | YTD net patient revenue increased $19M, supplemental state payments decreased and state tax increased. |
| Income(Loss) from Operations | (16,512) | 5,319 | Operating expenses increased $42M due to costs of drugs and medical supplies; professional fees for EPIC support, nurse registry fees, merger due diligence, JMMC acquisition and purchase accouting including depreciation and SFMG's increased loss of ($2.7M). |
| Revenue Over/(Under) Expense | (19,844) | (11,271) | Variance in swap activity of $17.8M |
| EBITDA | 11,804 | 30,785 | YTD net patient revenue increased $19M, supplemental state payments decreased and state tax increased. Operating expenses increased $42M due to costs of drugs and medical supplies; professional fees for EPIC support, nurse registry fees, merger due diligence and JMMC acquisition. SFMG's YTD loss increased ($2.7M). |
| Patient Cash Collected | NA | NA | |
| Cash and Cash Equivalents | 100,142 | 127,634 | Decrease in a/p ($7.3M); increase in due from affiliates $13.7M; funds expended for tail liablility $8.5M; JMMC purchase $2.3M; decrease in supplemental payments from the State; SWAP and debt termination expenses |
| Net Working Capital | 106,041 | 123,695 | Decrease in cash and cash equivalents ($26.7M); decrease in a/r patient ($4.6M), decrease in a/p ($7.3M) |
| Unrestricted Assets | 93,165 | 125,633 | YTD loss ($16.5M); increase pension liability due to change in mortality tables offset by transfer of SWAP liability to Trinity |

# Prefiled Testimony of James Richard O'Connell, Executive Vice President, East Group - Trinity Health

**STATE OF CONNECITUCUT**
**DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF HEALTH CARE ACCESS**
**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**
**DOCKET NUMBER: 15-32045-CON**
**May 9, 2016**

**Prefilled Testimony of James Richard O'Connell, Executive Vice President, East Group**

Good afternoon,

I am James Richard O'Connell, Executive Vice President, East Group, Trinity Health and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak with you today about Trinity Health and to seek the Office of Health Care Access' approval for the continued growth of Trinity Health-New England, Inc., our Regional Health Ministry for Connecticut and Western Massachusetts.

At Trinity Health, our mission is to serve together in the Spirit of the Gospel as a compassionate and transforming healing presence within our communities. Our five core values guide our work:

- Reverence
- Commitment to those who are poor
- Justice
- Stewardship
- Integrity

As a mission-driven innovative healthcare organization, our vision is to be the national leader in improving the health of our communities and each person we are privileged to serve.

We have the opportunity to serve a diverse population within our communities. Our vision as a mission-driven innovative health care organization is that we will become the national leader in improving the health of our communities and each person we serve. We aspire to become the most trusted health partner for life.

We are also dedicated to building a people centered health system that allows its organization to promote efficient and effective care management initiatives. These initiatives are helping us to shift our health care delivery approach from managing episodic events to providing a system of healthcare delivery focused on preserving the wellbeing and health of each person individually within our communities.

Since we last spoke to you in July 2015, Trinity Health has grown. Today, Trinity Health is a Catholic Health Care System that operates 90 acute care hospitals in 21 states as well as a wide range of home care, hospice, senior living and programs for the elderly. Our system employs about 95,000 full time employees including 3,900 employed physicians and we are affiliated with over 23,900 private practicing physicians as well.

Trinity Health supports the addition of Saint Mary's Hospital, Inc. and its related organizations to our Regional Health Ministry as an important step in the transition from episodic care delivery to a more holistic management approach of the health of individuals. This holistic management approach will deliver and promote better health while delivering excellent care at a lower cost to those who will require our services. Building a strong Regional Health Ministry requires addition of proven health providers such as Saint Mary's.

Trinity Health is excited about this opportunity. It is an honor and privilege to be here in support of this important endeavor.

I am available to answer any questions you have of me.

# Prefiled Testimony of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

**STATE OF CONNECITUCUT**
**DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF HEALTH CARE ACCESS**
**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**
**DOCKET NUMBER: 15-32045-CON**
**May 9, 2016**

**Prefilled Testimony of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.**

Good afternoon,

I am Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc. and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak to you today about our proposal to add Saint Mary's Hospital, Inc. to our growing system.

Since we formed Trinity Health-New England, Inc. in October 2015, our system and Trinity Health nationally has continued to grow.

Adding Saint Mary's Hospital, Inc. and its related entities to Trinity Health-New England, Inc. will strengthen with Saint Mary's and our system by:

- Continuing acceleration of our efforts to create a regional population health management model that builds on low cost, high quality and the provision of the right care at the right time in the most appropriate health care setting;

- Improving access to capital for strategic growth and clinical service enhancements;

- Supporting future capital investments of both organizations as well as securing Saint Mary's existing and future pension liabilities;

- Supporting system-wide efforts to recruit scarce health professionals and enhance the quality of the health services delivered to our patients through participation in evidence based initiatives and medical service innovation programs.

- Preserving Saint Mary's non-profit mission and Catholic identity, with its rich history of service to the Waterbury community, spanning nearly 110 years;

As was noted in the Certificate of Need application, Saint Mary's Hospital, Inc. began its search for a partner in February 2015. Once all regulatory approvals are obtained, Saint Mary's will join Trinity Health-New England, Inc. and two members of the Saint Mary's Hospital, Inc. community will be appointed to the Trinity Health-New England, Inc. Board of Directors.

Once approved, Saint Mary's will join the other organizations that make up Trinity Health-New England, Inc. and support our continued efforts to promote the health of all those who choose to use the health services provided by Trinity Health-New England, Inc.

I am available to answer any questions you have of me.

# Prefiled Testimony of Robert J. Mazaika, Chairman of the Board, Saint Mary's Health System

**STATE OF CONNECTICUT**

**DEPARTMENT OF PUBLIC HEALTH**

**OFFICE OF HEALTH CARE ACCESS**

**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**

**DOCKET NUMBER: 15-32045-CON**

**May 9, 2016**

**Prefiled Testimony of Robert J. Mazaika, Chairman of the Board, Saint Mary's Health System**

Good afternoon,

I am Robert Mazaika and I hereby adopt my testimony as submitted to the Office of Health Care Access.

The decision to become a part of Trinity Health – New England represents the culmination of a long and arduous process for Saint Mary's.

Our search for a strategic partner has been underway for more than 10 years. During this time we have met with many hospitals and health systems from around the country. As many of you know, we have made other proposals prior to this one. However, for a number of reasons those proposals were never brought to fruition.

In my role as Chairman of the Board, as well as the chair of our Strategic Partner Task Force, I can say with great confidence and conviction that this is truly the best possible outcome for Saint Mary's, our staff, and most importantly—the communities we serve.

Our selection process was extremely rigorous. Because we were considering our options from a position of strength, we did not need to rush in to a decision, or compromise our principles. Our task force, and our board, carefully considered a number of options over a long period of time. Throughout this period, the healthcare industry has continued to evolve at a rapid pace. However, we have remained steadfast in our commitment to our principles.

When we began this process more than a decade ago, Archbishop Henry J. Mansell established a Task Force, and in turn created a series of "Guiding Principles for Affiliation" (attached herein), which served as our litmus test for any potential partner we were considering. Those principles included philosophical, financial, strategic, and people requirements.

- The **philosophical** principles focused on maintaining our community-based Mission, improving the delivery of care, and adhering to the Ethical and Religious Directives while maintain our Catholic identity.
- The **financial** principles focused on improving the net asset value of Saint Mary's, gaining access to capital, and satisfying our pension liability.
- The **strategic** principles included improving technology and the standard of care, and gaining access to regional and national resources.
- Finally, the **people** principles were focused on improving the recruitment and retention of talent, and creating opportunities to strengthen partnerships with the medical staff.

Trinity Health meets these principles to a degree unsurpassed by other health systems. They are not only a good fit for Saint Mary's; they represent a direct match for our heritage, our culture, our community, and our vision of the future. The size and strength of Trinity Health, the third largest health system in America, will provide the necessary financial resources to backstop our balance sheet, provide necessary capital well into the future, and enhance our ability to attract talented physicians and clinicians who are the life blood of our health system.

On behalf of our Board of Directors, who represent the communities we serve, I urge you to approve this proposal, which will allow Saint Mary's to continue its mission of delivering quality healthcare in a spiritually enriched environment well in to the future.

Thank you.

## Guiding Principles

SMHS will utilize the following guiding principles in evaluating potential partners:

### Philosophical

- Fulfill our community-based Mission
- Improve the delivery of quality care
- Adhere to Ethical and Religious Directives and secure our Catholic Identity
- Maintain local governance and provide locally-based healthcare as part of a regional or national healthcare delivery system
- Enhance our current position as a charitable health system and hospital while being open to all possible structures to best serve the interest of Saint Mary's and our community

### Strategic Position

- Acquire the necessary capital to sufficiently address our strategic capital needs
- Improve technology and the overall standard of care
- Provide regional and/or national scale, leverage and resources to address Health Reform requirements
- Improve future opportunity to regionalize and rationalize the Waterbury healthcare delivery system

### Financial

- Improve the net asset value of Saint Mary's
- Improve access to and cost of capital
- Fully satisfy unfunded pension liability
- Improve opportunities to reduce costs by creating efficiencies and economies of scale
- Improve revenue cycle opportunities

### People

- Improve our ability to meet our obligations to our staff
- Improve recruitment and retention of talent
- Create opportunities to strengthen partnerships with the Medical Staff

# Prefiled Testimony of Steven E. Schneider, MD, Chief Medical Officer, Saint Mary's Hospital

**STATE OF CONNECTICUT**

**DEPARTMENT OF PUBLIC HEALTH**

**OFFICE OF HEALTH CARE ACCESS**

**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**

**DOCKET NUMBER: 15-32045-CON**

**May 9, 2016**

**Prefiled Testimony of Steven E. Schneider, MD, Chief Medical Officer, Saint Mary's Hospital**

Good afternoon,

I am Dr. Steven Schneider and I hereby adopt my testimony as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak with you today.

In my role as Chief Medical Officer I am focused on working effectively with both the medical staff and leadership and management of Saint Mary's.

I am very pleased to report that the proposal to become part of Trinity Health – New England has been met with widespread support from the medical staff.

As we all know, the healthcare delivery system is changing dramatically. Nobody experiences this more directly than physicians, who are at the forefront of patient care. While most physicians recognize the need for these changes, and are, in fact helping to drive and implement them, there is a sense of uncertainty that accompanies change of this magnitude.

Here in Connecticut, and specifically Waterbury, the changing landscape has left many physicians seeking a sense of stability. Becoming part of Trinity Health – New England provides exactly the sense of confidence and clear direction that many of our medical staff members desire.

Becoming part of Trinity Health – New England will strengthen and enhance a number of critical issues, including:

**Physician recruiting and retention**

Maintaining a vibrant, dynamic, and stable medical staff is essential to the health of our community. This applies to both primary care physicians and specialists. Yet recruiting physicians to our community has been a challenge. Becoming part of one of the largest health systems in the nation, with all of the attendant benefits, will make us far more attractive to physicians.

**Investment in technology and facilities**

New physicians are being trained using the most current clinical technologies, and they expect these to be available where they practice. This applies to everything from electronic health records to the most advanced clinical equipment. Having access to capital through Trinity Health will greatly enhance our ability to create and maintain the kind of environment that today's most talented and capable physicians expect and deserve.

**Changes in the care delivery system**

The care delivery system of the future will be very different than it is today, with an emphasis on value-based reimbursement and population health management. Functioning in this environment will require different skills and different structures. Becoming part of a large regional and national system will allow the Saint Mary's medical staff to prepare for and ultimately thrive in this new environment

Through my many discussions with the physicians in our community it is clear that they understand the challenges that lie ahead. It is also clear that physicians want the kind of proactive, forward-looking action this represents.

I urge you to look favorably upon this proposal and approve Saint Mary's becoming a member of Trinity Health – New England.

Thank you.

# Prefiled Testimony of Chad W. Wable, President & Chief Executive Officer, Saint Mary's Hospital

**STATE OF CONNECTICUT**

**DEPARTMENT OF PUBLIC HEALTH**

**OFFICE OF HEALTH CARE ACCESS**

**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**

**DOCKET NUMBER: 15-32045-CON**

**May 9, 2016**

**Prefiled Testimony of Chad W. Wable, President & Chief Executive Officer, Saint Mary's Hospital**

Good afternoon,

I am Chad Wable and I hereby adopt my testimony as submitted to the Office of Health Care Access.

This hearing represents a significant milestone in the history of Saint Mary's and I am pleased to have the opportunity to speak with you today.

I moved to Connecticut and became a member of the Saint Mary's family in 2002. One of my first responsibilities was to work with our board to develop a new strategic plan for Saint Mary's. Our first strategic imperative, as far back as 2002, was to establish a partnership. So this is something that I have been working towards literally for as long as I have been at Saint Mary's.

During the past 13 years much has changed. Saint Mary's has become a far stronger and more financially stable organization. We have made incredible progress in clinical quality and safety. We have gown and added services. All around us, the healthcare landscape has changed at an unprecedented pace. We have witnessed the passing and implementation of the Affordable Care Act, the widespread adoption of electronic health records, the introduction of value-based purchasing and population health management. Here in Connecticut the landscape has changed significantly, with hospitals moving rapidly towards a system-based delivery model.

Similarly, Saint Mary's need to join a national or regional healthcare delivery system has evolved. What was once a financially driven decision is now a purely strategic issue.

Saint Mary's vision states that we "will become an integrated network of healthcare providers creating exceptional value for those we serve through trusted partnerships that empower and transform lives."

Becoming part of Trinity Health will help us achieve this vision and accelerate the implementation of our strategic plan. Trinity's "People 2020" strategy is perfectly aligned with ours, and joining Trinity will help us with critical issues such as scale, resources, efficiency and expertise as we make the move towards population health. The specific benefits to Saint Mary's as a result of this proposal include:

- Having access to the resources of a large system which will allow SMHS to continue to provide quality health care services in the greater Waterbury area and be able to expand those services within its service area by making them more accessible to a greater number of people;
- Having the resources necessary to help develop more preventive and primary care services in the greater Waterbury area;
- Meeting the demands of the 2010 Patient Protection and Affordable Care Act which requires an emphasis on value rather than volume in terms of reimbursement for health care services;
- Creating efficiencies so that health resources are not wasted, which will also enable more patients to be served;
- Having readily available access to capital and financing for that capital at favorable interest rates; and
- Developing a plan to address Saint Mary's pension plan obligation.

Although the details of our proposal are contained in our application, there are a few highlights that bear mentioning. This proposal is an organizational change that will allow Saint Mary's to become part of Trinity Health – New England. There is no change in clinical services requested, nor is there any change of location involved with any of the clinical services now being offered by SMHS as a direct result of this proposal. Further, there is no capital cost associated with the Transfer Agreement between the Parties.

Additionally, Trinity Health has agreed to ensure the expenditure of One Hundred Million Dollars for capital expenditures at Saint Mary's over the first five years following the effective date of the Transaction. This committed capital will be available to support the capital needs of Saint Mary's,

including strategic growth and infrastructure development for it's integrated delivery system including both facilities and physician network development.

As a result of this Transfer Agreement, the Parties intend to:

- improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area, including SMHS's Waterbury service area;
- enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to safety and satisfaction;
- reduce the costs of healthcare in the NE-RHM Service Area, including SMHS's Waterbury service area;
- Support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

Finally, Trinity's heritage, culture, and values are a perfect match for Saint Mary's, and help make this a time of great excitement and optimism. The opportunity before us to become a member of a not-for-profit, Catholic health care organization is an extremely straight-forward transaction; however it is very significant. This transaction will cement our over100 year history into the business and healthcare fabric of Waterbury for another 100 years. The heritage and work of our founders and the Sisters of St. Joseph's will be protected. We are privileged to have the opportunity to join Trinity Health, an impressive, national, people centered organization with great talent, resources and values.

Our CON application provides much more information on this proposal.

I look forward to answering any questions you may have.

Thank you.

# Closing Remarks of James Richard O'Connell, Executive Vice President, East Group - Trinity Health

**STATE OF CONNECITUCUT**
**DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF HEALTH CARE ACCESS**
**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**
**DOCKET NUMBER: 15-32045-CON**
**May 9, 2016**

## Closing Remarks of James Richard O'Connell, Executive Vice President, East Group

Trinity Health's vision of becoming a national leader in improving the health of our communities and the most trusted health care partner for Life for each person we serve will be strengthened by the addition of Saint Mary's Hospital and Health System to our Regional Health Ministry, Trinity Health – New England, Inc.

We recognize the many challenges faced by Connecticut today, but know that forging local partnerships with committed, high quality, non- profit health care providers is the key to ensuring a truly integrated health system that promote better healthcare for all.

We also believe that preserving Catholic healthcare institutions is also critically important to ensuring our unique approach will provide the neediest people in each local community the access to care they deserve.

Thank you for your continued support of Trinity Health's collective efforts to create a better tomorrow for all we serve.

# Closing Remarks of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.

**STATE OF CONNECITUCUT**
**DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF HEALTH CARE ACCESS**
**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**
**DOCKET NUMBER: 15-32045-CON**
**May 9, 2016**

**Closing Remarks of Christopher M. Dadlez, President and CEO, Trinity Health-New England, Inc.**

Since 2015 when Trinity Health - New England Inc. was formed our goal of offering people centered health care closer to home has made significant strides in a very short time. Our efforts toward improving population health, enhancing the patient care experience and controlling cost while maintaining a positive margin will be strengthened with the addition of Saint Mary's Hospital and Health System to our organization.

Equally important the 100 plus years of Saint Mary's exemplary service to the Waterbury community is both preserved and strengthened.

If approved, together the organizations that would constitute Trinity Health – New England, Inc. represent over 300 years of continuous, high quality, non –profit health care service delivery to multiple communities across the state of Connecticut.

Our institutions are open 24 hours a day, seven days a week to all in need. Trinity Health – New England Inc. is truly a part of the fabric of Connecticut's health system. Please support its efforts to continue to serve the citizens of Connecticut for another hundred years.

Thank you very much.

# Closing Remarks of Chad W. Wable, President and CEO, Saint Mary's Hospital

**STATE OF CONNECITUCUT**
**DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF HEALTH CARE ACCESS**
**CERTIFICATE OF NEED APPLICATION FOR TRINITY HEALTH-NEW ENGLAND TO BECOME THE SOLE MEMBER OF SAINT MARY'S HOSPITAL, INC.**
**DOCKET NUMBER: 15-32045-CON**
**May 9, 2016**

**Closing Remarks of Chad W. Wable, President and CEO, Saint Mary's Hospital**

Saint Mary's is integral to the fabric of Greater Waterbury. This proposal will position us to maintain our identity as a faith-based, not-for-profit hospital and continue our great tradition of service to the community for many years to come.

Becoming part of a regional or national system has been at the core of our strategic plan for many years. Trinity Health provides all of the resources and expertise needed to accelerate and implement our strategic plan, while also honoring our faith based heritage and deep community roots. Our collective commitment to people-centered care will be the foundation of all that we do.

The creation and growth of a strong, progressive regional health ministry serving New England positions Saint Mary's to effectively deal with the shift to population health management and other changes in the healthcare delivery system locally and regionally. Our ability to invest in our future will help us to attract and retain the most talented physician and caregivers, and provide our patients and families with the most appropriate standard of care.

Our vision of the future is bright. On behalf of the 2,000 members of the Saint Mary's family we look forward to having our proposal approved so we can begin the exciting work of making our vision a reality.

Thank you for the opportunity to present our proposal.

## Greer, Leslie

**From:** Mercier, Carlene M. <CMercier@brownrudnick.com>
**Sent:** Tuesday, May 10, 2016 1:45 PM
**To:** User, OHCA
**Cc:** chartley@stfranciscare.org; Anthony, Robert J.; Teitelbaum, Claudia S.; helmecki@ct.gov
**Subject:** Docket No. 15-32045-CON / Appearance
**Attachments:** Saint Mary_s _ Trinity - Appearance for R. Anthony.PDF

Hello,

Attached for filing in Docket No. 15-32045 (Saint Mary's / Trinity - Transfer of Ownership) is an Appearance for Bob Anthony on behalf of Saint Mary's. Please let me know if you need anything further.

Best Regards,
Carlene

**Carlene M. Mercier**
**Paralegal**
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**STATE OF CONNECTICUT**
**DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF HEALTH CARE ACCESS**

| | | |
|---|---|---|
| **IN RE** | : | **Docket No. 15-32045-CON** |
| | : | |
| **CERTIFICATE OF NEED APPLICATION FOR SAINT MARY'S HEALTH SYSTEM, INC. AND SAINT MARY'S HOSPITAL, INC.'S TRANSFER OF OWNERSHIP AND CONTROL TO TRINITY HEALTH – NEW ENGLAND, INC., FORMERLY KNOWN AS SAINT FRANCIS CARE, INC.** | : | **MAY 10, 2016** |

**APPEARANCE**

An appearance on behalf of Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. in the above-mentioned docket is hereby submitted.


Robert J. Anthony, Esq.
Brown Rudnick LLP
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Respectfully Submitted,

Robert J. Anthony/cm


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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

SAINT MARY'S HEALTH SYSTEM, INC.
TRINITY HEALTH, INC.

TRANSFER OF OWNERSHIP OF SAINT MARY'S
HOSPITAL SYSTEM TO TRINITY HEALTH, INC.

DOCKET NO. 15-32045-CON

MAY 9, 2016

3:00 P.M.

COURTYARD BY MARRIOTT WATERBURY
63 GRAND STREET
WATERBURY, CONNECTICUT

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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 Saint Mary's Health System, Inc., Trinity Health, Inc., transfer of ownership of Saint Mary's Hospital System to Trinity Health, Inc., held at the Courtyard by Marriott Waterbury, 63 Grand Street, Waterbury, Connecticut, on May 9, 2016 at 3:00 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Okay, folks, we're going to get started here. Okay, we're on the record. Good afternoon, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 15-32045-CON, is being held on May 9, 2016 to consider Saint Mary's Health System, Inc. and Trinity Health, Inc.'s application for the transfer of ownership of Saint Mary's Hospital system to Trinity Health, Inc.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, 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 to serve as the Hearing Officer for this matter.

The staff members assigned to this case are Kaila Riggott, Jessica Schaeffer-Helmecki, David Fernandes and Ronald Ciesones. The hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

Saint Mary's Health System, Inc. and Trinity Health Corporation have been designated as parties in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this matter.

All documents have been identified in the Table of the Record for reference purposes.

MS. JESSICA SCHAEFFER-HELMECKI: My name is Jessica Schaeffer-Helmecki, and, on behalf of OHCA, I'd like to request that Exhibits A through L be entered into the record.

HEARING OFFICER HANSTED: Thank you. And there is one correction I'd like to make, just one bit of housekeeping.

On the order regarding administrative notice, dated April 27, 2016, which is Exhibit K on the Table of the Record, in that order, letter B, it says Exhibit D, completeness responses, page 1974. The page number should be 1947.

Does the Applicant have any objection to any of the exhibits? No objection? If you could just state that on the record?

MR. CHRIS HARTLEY: Chris Hartley, St. Francis. For the record, no.

HEARING OFFICER HANSTED: Okay, thank you. And for this afternoon's hearing, we will first hear from the Applicant for an overview of the project, and then, if there are any individuals signed up to give public comment, we will hear from them.

We, of course, will take elected officials first, and then read the names off of the public comment sign-up sheet in the order that they have signed up.

Then, after the public comment, we will have some questions from OHCA, and then, if there are any other public commenters, we will take them at that time.

And, at this point, would all the individuals, who are going to or think they may testify, please stand, raise your right hand and be sworn in by the court reporter?

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Okay, thank you, all. And just for clarity on the record, each of you, who have just taken the oath, would you please identify yourself in one of the microphones closest to you, including the folks sitting in the back rows? Whoever wants to start can do so.

MR. RALPH BECKER: Ralph Becker with Saint Mary's.

MR. DAVID BITTNER: David Bittner. I'm the Chief Financial Officer for Trinity Health New England.

MS. JENNIFER SCHNEIDER: Jennifer Schneider, Vice President of Finance, St. Francis Hospital and Medical Center.

MR. HARTLEY: Chris Hartley, St. Francis.

MR. CHRISTOPHER DADLEZ: Christopher Dadlez, President and CEO, Trinity Health New England.

MR. JAMES RICHARD O'CONNELL: James

Richard O'Connell, Trinity Health.

MR. CHAD WABLE: Chad Wable, President and CEO, Saint Mary's Hospital and Saint Mary's Health System.

MR. ROBERT MAZAIKA: Robert J. Mazaika, Chairman of the Board of Saint Mary's Health System.

DR. STEVEN SCHNEIDER: Dr. Steve Schneider, Chief Medical Officer, Saint Mary's Hospital.

MR. JOE CONNOLLY: Joe Connolly, Vice President of Administration, Saint Mary's Hospital.

MR. BOB ANTHONY: Bob Anthony, attorney for Saint Mary's Hospital.

HEARING OFFICER HANSTED: Okay, thank you. And I know we have some folks in the second row.

DR. ADAM SILVERMAN: Adam Silverman, Vice President, Ambulatory Strategy, Trinity Health New England.

DR. MARCUS McKINNEY: Marcus McKinney, Vice President of Community Health, Trinity Health New England.

MR. MICHAEL TALBERT: Michael Talbert, attorney for Trinity Health New England.

MS. LIZ RODAREO: Liz Rodareo, St. Francis Hospital.

MR. JIM HARRIS: Jim Harris, Trinity Health New England.

MR. JURCZYK: Kyle Jurczyk, Saint Mary's Hospital.

MR. CHRIS HAYES: Chris Hayes, Saint Mary's Hospital.

HEARING OFFICER HANSTED: Okay. I think that's everyone. And for the two attorneys that are present here today, I know we have one for the hospital and one for Trinity, do you intend on filing appearances in this matter?

MR. ANTHONY: Yes. This is Bob Anthony. Yes, we do.

HEARING OFFICER HANSTED: Okay. All right. Would you just file those this week, just so I have them on the record? Thank you.

Okay, at this point, the Applicants may proceed with their opening presentation.

MR. O'CONNELL: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. O'CONNELL: I'm James Richard O'Connell, Executive Vice President of the East Group for Trinity Health, and I hereby adopt my testimony, as submitted for the Office of Health Care Access.

HEARING OFFICER HANSTED: Thank you.

MR. O'CONNELL: Thank you for the opportunity to speak to you today about Trinity Health and to seek the Office of Health Care Access approval for the continued growth of Trinity Health New England, Inc., our regional health ministry for Connecticut and Western Massachusetts.

At Trinity Health, our mission is to serve together in the spirit of the gospel as a compassionate and transforming, healing presence within our communities.

Our five core values guide our work; reverence, commitment to those who are poor, justice, stewardship, integrity.

As a mission-driven innovative health care organization, our vision is to be the national leader in improving the health of our communities and each person we are privileged to serve.

We have the opportunity to serve a diverse population within our communities. Our vision as a mission-driven innovative health care organization is that we will become a national leader in improving the health of our communities and each person we serve. We aspire to become the most trusted health care partner for

life.

We are also dedicated to building a people-centered health care system that allows its organization to promote efficient and effective care management initiatives.

These initiatives are helping us to shift our health care delivery approach for managing episodic events to providing a system of health care delivery focused on preserving the well-being and health of each person individually within our communities.

Since we last spoke to you in July of 2015, Trinity Health has grown. Today, Trinity Health is a Catholic health care system that operates 90 acute care hospitals in 21 states, as well as a wide range of home care, hospice, senior living and programs for the elderly.

Our system employs about 95,000 full-time employees, including 3,900 employed physicians, and we are affiliated with over 23,900 private practicing physicians, as well.

Trinity Health supports the addition of St. Mary's Hospital, Inc. and its related organizations to our regional health ministry as an important step in the transition from episodic care delivery to the more

holistic management approach of the health care of individuals.

This holistic management approach will deliver and promote better health while delivering excellent care at a lower cost to those, who require our services.

Building a strong regional health ministry requires addition of proven health providers, such as Saint Mary's. Trinity Health is excited about this opportunity. It is an honor and a privilege to be here in support of this important endeavor.

I'm available to answer any questions you may have of me.

HEARING OFFICER HANSTED: Thank you.

MR. DADLEZ: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. DADLEZ: I'm Christopher M. Dadlez, President and CEO of Trinity Health New England, and I hereby adopt my testimony, as submitted to the Office of Health Care Access.

Thank you for the opportunity to speak to you today about our proposal to add Saint Mary's Hospital to our growing system.

Since we formed Trinity Health New England

in October of 2015, our system and Trinity Health nationally has continued to grow. Adding Saint Mary's Hospital and its related entities to Trinity Health New England will strengthen Saint Mary's and our system by continuing acceleration of our efforts to create a regional population health management model that builds on low cost, high quality, and the provision of the right care at the right time in the most appropriate health care setting.

Improving access to capital for strategic growth and clinical service enhancements, supporting future capital investments at both organizations, as well as securing Saint Mary's existing and future pension liabilities, supporting system-wide efforts to recruit scarce health care professionals and enhance the quality of the health services delivered to our patients through participation in evidence-based initiatives and medical service innovation programs.

Also, preserving Saint Mary's not-for-profit mission and Catholic identity with its rich history of service to the Waterbury community spanning nearly 110 years.

As was noted in the Certificate of Need application, Saint Mary's Hospital began its search for a

partner in February 2015. Once all regulatory approvals are obtained, Saint Mary's will join Trinity Health New England, and two members of the Saint Mary's Hospital community will be appointed to the Trinity Health New England Board of Directors.

Once approved, Saint Mary's will join the other organizations that make up Trinity Health New England and support our continued efforts to promote the health of all those, who choose to use the health services provided by Trinity Health New England, Inc.

I'm available to answer any questions you may have. Thank you so much.

HEARING OFFICER HANSTED: Thank you.

MR. WABLE: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. WABLE: I'm Chad Wable, President and CEO of Saint Mary's Hospital and Saint Mary's Health System, and I hereby adopt my pre-filed testimony.

First of all, I'd like to thank all of you for bringing us together today for this very important hearing. I want to thank all of you and the involved agencies for the diligence and work in reviewing our application.

Since 2002, Saint Mary's saw the value and

1 importance in forming a broader, larger partnership with
2 a national or regional system. Over the past decade,
3 we've been truly blessed to have been able to grow
4 stronger and more stable and to affirm ourselves as a
5 highly-respected and trusted hospital and health care
6 company.
7 We have added services and programs. We
8 have added numerous jobs. We have added several
9 physicians and clinicians to our medical group and
10 medical staff to better serve the Greater Waterbury area.
11 Everything we do at Saint Mary's is
12 grounded in our Catholic values and mission and focused
13 by our vision, a vision perfectly aligned with Trinity's
14 vision and their People 2020 strategy.
15 Joining Trinity is almost surreal to me,
16 considering what we have been able to accomplish
17 independently and our many attempts at forming a larger,
18 broader strategic partnership through the years.
19 This partnership with Trinity Health is so
20 perfect for us and so perfect for our people in our
21 community. The scale, the resources, the efficiency and
22 expertise will certainly move us towards our collective
23 vision of value in population health.
24 The benefits to Saint Mary's of joining

Trinity Health are endless. Our proposal was so straightforward, Catholic-to-Catholic, not-for-profit and not-for-profit and so on.

And through our member substitution, there's nearly no organizational changes, no service changes, and no exchange of money.

What does change is we, in our community, get a great deal of stability, security, certainty and confidence in Saint Mary's, confidence in health care for Waterbury, and confidence for the health of our community as we look so positively to the future.

This is a time of great enthusiasm, a time of great excitement, and a time of great optimism for the entire Saint Mary's family and for the Greater Waterbury community.

What is most perfect is this transaction will cement our over 100-year history into the business and health care fabric of Waterbury for another 100 years.

The heritage and work of our founders and sisters of St. Joseph's will be protected, and it will live on with great hope and promise.

We are privileged to have the opportunity to join Trinity Health, an impressive, national, people-

centered organization, with great talent, resources and values.

I look forward to answering any questions that you may have.

HEARING OFFICER HANSTED: Thank you.

MR. MAZAIKA: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. MAZAIKA: I'm Robert J. Mazaika, Chairman of the Board of Saint Mary's Health System. I hereby adopt my testimony, as submitted to the Office of Health Care Access.

The decision to become part of Trinity Health New England represents the culmination of a long and arduous process for Saint Mary's Health System.

Our search for a strategic partner has been underway for more than 10 years. During this time, we have met with many hospitals and health systems from around the country.

As many of you know, we have made other proposals prior to this one, however, for a number of reasons, those proposals were never brought to fruition.

In my role as Chairman of the Board, as well as Chair of our Strategic Partner Task Force, I can say with great confidence and conviction that this is

truly the best possible outcome for Saint Mary's, our staff, and, most importantly, the communities we serve.

Our selection process was extremely rigorous, because we were considering our options from a position of strength. We did not need to rush into a decision or compromise our principles.

Our Task Force and our Board carefully considered a number of options over a long period of time. Throughout this period, the health care industry has continued to evolve at a rapid pace, however, we have remained steadfast in our commitment to our principles.

When we began this process more than a decade ago, Archbishop Henry J. Mansell established a Task Force, and, in turn, created a series of guiding principles for affiliation, which served as our litmus test for any potential partner we were considering.

Those principles included philosophical, financial, strategic and people requirements. The philosophical principles focused on maintaining our community-based mission, improving the delivery of care, and adhering to the ethical and religious directives, while maintaining our Catholic identity.

The financial principles focused on improving the net asset value of Saint Mary's, gaining

access to capital, and satisfying our pension liability. The strategic principles included improving technology and the standard of care and gaining access to regional and national resources.

Finally, the people principles were focused on improving the recruitment and retention of talent and creating opportunities to strengthen partnerships with our medical staff.

Trinity Health meets these principles to a degree unsurpassed by other health systems. They are not only a good fit for Saint Mary's. They represent a direct match for our heritage, our culture, our community and our vision for the future.

The size and strength of Trinity Health, the third largest health system in America, will provide the necessary financial resources to backstop our balance sheet, provide necessary capital well into the future, and enhance our ability to attract talented physicians and clinicians, who are the life blood of our health system.

On behalf of our Board of Directors, who represent the communities we serve, I urge you to approve this proposal, which will allow Saint Mary's to continue its mission of delivering quality health care in a

spiritually-enriched environment well into the future.

Thank you very much for your attention.

HEARING OFFICER HANSTED: Thank you.

DR. SCHNEIDER: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

DR. SCHNEIDER: I am Dr. Steve Schneider, Chief Medical Officer at Saint Mary's Hospital, and I hereby adopt my testimony, as submitted to the Office of Health Care Access. Thank you very much for the opportunity to speak with you today.

In my role at the hospital as Chief Medical Officer, I am focused primarily on working effectively with both the medical staff and the leadership and management of Saint Mary's Hospital.

I am very pleased to report that the proposal to become part of Trinity Health New England has been met with widespread support from our medical staff.

As we all know, the health care delivery system is changing dramatically. Nobody experiences this more directly than physicians, who are at the forefront of patient care.

While most physicians recognize the need for these changes and are, in fact, helping to drive and implement them, there is a sense of uncertainty that

accompanies change of this magnitude.

Here in Connecticut and, specifically, in Waterbury, the changing landscape has left many physicians seeking a sense of stability.

Becoming part of Trinity Health New England provides exactly that sense of confidence and clear direction that many of our medical staff members and physicians in the community desire.

Becoming part of Trinity Health New England will strengthen and enhance a number of critical issues, including first physician recruiting and retention. Maintaining a vibrant dynamic and stable medical staff is essential to the health and well-being of the community.

This applies to both primary care physicians and specialists, yet recruiting physicians to our community has been a challenge.

Becoming one of the largest health systems in the nation, with all of the benefits, will make us far more attractive to physicians.

Next, investment and technology and facilities. New physicians are being trained using the most current clinical technologies, and they expect these technologies to be available where they practice.

This applies to everything, from electronic health records to the most advanced clinical equipment. Having access to capital through Trinity Health will greatly enhance our ability to create and maintain the kind of environment that today's most talented and capable physicians expect and deserve.

Lastly, changes in the health care delivery system, itself. The health care delivery system of the future will be very different than it is today, with an emphasis on value-based reimbursement and population health management.

Functioning in this environment will require different skills and different structures. Becoming part of a large regional and national system will allow the Saint Mary's medical staff to prepare for and ultimately thrive in this new environment.

Through my many discussions with physicians in our community, it's clear that they understand the challenges that lie ahead. It is also clear that physicians want the kind of proactive, forward-looking action that this represents.

I urge you to look favorably upon this proposal and approve Saint Mary's becoming a member of Trinity Health New England. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. HARTLEY: That concludes our initial presentation.

HEARING OFFICER HANSTED: Okay, thank you.

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: We will go to OHCA's questions. Ms. Riggott, do you want to begin?

MS. KAILA RIGGOTT: Sure. Kaila Riggott, OHCA staff. I'm not sure. There may be different individuals, who will answer these questions, so I'll just pose them generally.

Based on your application, pre-filed testimony, etcetera, OHCA has certain areas of interest we'd like to have a brief discussion about and also want to understand if you have any concerns or challenges regarding them. These would include CHNAs, community benefit, Board makeup, etcetera.

You've mentioned in your response to OHCA's interrogatories that the CHNA is scheduled to be completed in June and the implementation plan mid-November.

In your application, you stated that the New England Regional Health Ministry and Saint Mary's are currently addressing the community needs within the Saint

Mary's community and will continue to do so if the CON is approved.

Specifically, how will this proposal affect the implementation plan being developed to address priority health needs identified in the CHNA, how does Trinity and the Regional Health Ministry support the CHNA, and how will they be participating in the process?

MR. HARTLEY: Chris Hartley of St. Francis. I want to ask Joe Connolly to speak to where things stand on the Waterbury Community Health Needs Assessment, and then Dr. Marcus McKinney will talk about how we're integrating that with what we're doing in the rest of Trinity Health New England that ties to the Community Health Needs Assessment and Strategic Implementation Plan you raised as a question. Joe, you want to start?

MR. CONNOLLY: Sure. I'm Joe Connolly from Saint Mary's, and, as Bill Quinn said, we have a very robust partnership here in Waterbury that Saint Mary's is a founding partner of, both participation not only from health care providers, but, in addition to that, some of the other funders in the city, both of our large philanthropies are involved, and it's been an ongoing process.

We've used research that was conducted in 2013 when we did our initial needs assessment. We've re-upped and had another round of research that was completed earlier this year.

As opposed to changing anything, I think it's a refocusing, so, for instance, where we were talking about some of our chronic health conditions last time, this year, for instance, we're going to be looking at a more narrow focus on asthma, which is consistent with what's going on at the Connecticut Hospital Association, consistent with other programs here in the state, so I think that it's an evolution and a refocusing and a continuing of what has been set forth, and there's ongoing communication from all the partners to make sure that that work continues.

And, as Chris just alluded to, Marcus McKinney could add to that, but we certainly see, from the Saint Mary's perspective, that the experience and commitment that St. Francis is bringing to that and Trinity Health is going to help accelerate that and provide some perspective that we might not already have here in our community.

DR. McKINNEY: Hi. Marcus McKinney, Vice President for Community Health for Trinity Health New

England.

So several things surface to the top to try to address how we support for Trinity Health New England, the Waterbury area and Saint Mary's.

First, we would refer to the hub of community health and health equity work at our Trinity Health New England system is the Curtis D. Robinson Center for Health Equity.

That will be an approach that will allow for team extension into Waterbury, as it has in Springfield and in Hartford and for Johnson Hospital, Johnson Memorial Hospital.

That is a team of eight individuals, multi-cultural, multi-lingual, that really amends Vice President Connolly's comments, and, also, I would refer back to the earlier comments of the Director of Health in Waterbury, because the community health strategy that Trinity referenced to be a speaker of at ACHI meeting, the Community Health Improvement meeting in March, really is community health and well-being.

So what we would be glad to do for you is really highlight that the community health and well-being is the strategy, and well-being touches all those social determinant issues, so the strategy baits into the

priories of obesity, tobacco, to be at the highest level of concern for strategies that's already in the Greater Waterbury strategy, the partnership that was mentioned by the Director of Health, but really would be able to amend it by the resources and insight from a regional approach, which includes Hartford.

So our Center for Health Equity and the fact that we're looking at well-being and where are we getting that from, we're getting the information from the existing health needs assessment that's taking place by DataHaven, and DataHaven you may remember, some of you, is a first of its kind health and well-being assessment in this country, and it's for all of our hospitals that are implicated here in Connecticut.

So we have the first set of questions from the community that touches on social determinate issues. That will help inform implementation plans to support the Waterbury region and Saint Mary's.

MR. DADLEZ: In addition, we also had the national initiatives at the corporate headquarters of Trinity and Detroit, where we have a Senior Vice President for Community Outreach and his whole team that is providing resources for the regional ministries, in addition, so this is a comprehensive commitment that

Trinity Health has made significantly to the communities that it serves.

One of its primary focus is community outreach and community health and well-being and the people that we serve, so there are dramatic resources throughout the whole organization that are available.

MS. RIGGOTT: And just to follow-up on that, the resources would consist of?

MR. DADLEZ: First of all, resources that consist of the talent and the content experts that we have, both on a national level and a regional level.

I mean I think that first the priority is the mindfulness of that and the focus that we have and those people that have been trained and have been doing this work for years and years.

There's also a financial commitment that Trinity basically has set aside a significant portion of its budget this past year to really focus on things, like obesity and tobacco use and those kind of things in all the different regions comprehensively across the state.

They setup specific guides and parameters and expectations for each of the health ministries to meet all across the nation, so this is kind of -- the point is it's hardwired into what we do, and it's a very

1 significant commitment.
2 MS. RIGGOTT: Thank you. In the
3 application, it was stated that, for Trinity Health,
4 success will be measured against the triple aim
5 objectives, its ability to actually deliver on all three
6 dimensions of better health, better care and reduced
7 costs.
8 Does Trinity have any outcome data on
9 which to measure these successes?
10 MR. O'CONNELL: This is James O'Connell
11 from Trinity Health.
12 We have a lot of outcome measures and a
13 lot of strategic aims. What we've done is positioned
14 ourselves to where we want to be in the top quartile by
15 2020 in all of our ministries across the organization,
16 and those are all measured differently, so lowest cost
17 provider, highest quality and highest satisfaction.
18 We use national data to benchmark against,
19 so it's the HCAHPS for the patient care experience.
20 Quality, we have a very sophisticated quality score card
21 that measures across the full continuum of services that
22 we have, and we compute that into GPA, and we have all of
23 our facilities measured on that every month along the
24 way, so we know, prior to something happening, that we're

1 going in the wrong direction, or we're going in the right
2 direction, so we use those measures for our success.
3 The truth will be, you know, for those
4 payers at the end of the day, who want to contract with
5 us to provide their care, because they're going to look
6 for the highest quality, lowest cost facilities
7 available, and we hope to have 75 percent of all of our
8 contractual arrangements in an alternative payment form
9 by 2020. That's our other measure.
10 MS. RIGGOTT: Thank you. Next question.
11 OHCA is interested in encouraging community building
12 activities that are aimed at addressing the social and
13 economic determinants of health and examining the
14 outcomes and cost effectiveness of improvements that
15 result from community building activities.
16 Saint Mary's most recently submitted 990s.
17 I believe it shows that physical improvements and
18 workforce development appeared under the community
19 building activities.
20 With respect to community benefit and
21 community building, are there plans to align with the
22 CDC's 618 initiatives interventions and/or Healthy People
23 2020?
24 MR. CONNOLLY: The CDC program is one that

we participated in as a community this year, and the asset not only is Saint Mary's, but throughout the rest of the community, as well, so I think that it was -- we spent six months studying that. We had representatives actually participate in the meeting where a lot of those initiatives were laid out, and the recommendations that we are making not only to ourselves as an organization, but community-wide, are completely consistent with that, so I would say yes.

MS. RIGGOTT: Okay. In your application, also, you state that Saint Mary's is committed to supporting its community and is projecting a three percent increase annually as part of New England Regional Health Ministry, and Saint Mary's will be able to collaborate on planning activities on a regional level, leveraging the expertise and resources of the Regional Health Ministry.

Can you please confirm your plans to increase the level of community benefit provided as a result of this acquisition?

MR. HARTLEY: Can you tell us what page you're referring to?

MS. RIGGOTT: I believe it's page 85. I believe it mentions projecting a three percent increase

per year. I may not have the right page. It's at the response to the first part of --

MR. HARTLEY: Chris Hartley. I believe you're talking about the response above on Exhibit S6? Is that what you're talking about?

MS. RIGGOTT: Um-hum. Yeah. It refers to Exhibit 17, question O.

MR. HARTLEY: Chris Hartley, St. Francis. We're looking at page A46. This is talking about the increase in community benefits that's measured each year through our community benefits report and looks at how much increase in delivery of community benefits we've had.

If you look at our latest community benefit report for St. Francis, the actual $78 million we gave in 2014 in community benefits is measured by that program. It actually went to 104 million in 2015, primarily driven by the shortfalls in Medicaid payments for care and other government payments.

So one of the biggest contributors for the growth in that area is the continued reduction in provision of payments for Medicaid and Medicare patients that use services, and that commitment to continue to grow is basically exceeding three percent at this point

in time, and we'll continue that commitment to the patients that need our care, and, unfortunately, that care payment has been continually reduced as part of the program. That's what that's referred to.

MS. RIGGOTT: Thank you. And then, with respect to charity care, can you confirm for the record that you are committed to either maintaining or increasing the level of charity care as a result of the acquisition, and there would be no concerns in notifying OHCA if there were any changes in that level?

MR. HARTLEY: We provided information in the application that says that our charity care policies will continue. There should be no change.

What we did in the earlier applications, we actually met the most stringent standards of Trinity Health Care for our previous parts of the system. We'll continue to do it with Saint Mary's as part of the program.

MS. RIGGOTT: Thank you. My next question is regarding evidence-based initiatives. Mr. Dadlez, you mentioned in your pre-filed testimony the acquisition will enhance the quality of health services delivered to patients through participation in evidence-based initiatives and medical service innovation.

Can you elaborate a bit and discuss your top proprieties with respect to these initiatives and innovation?

MR. DADLEZ: Let me think what the best answer to that is. Pulling together an organization, such as we are, offers a tremendous opportunity to really develop and foster and grow really top quality health programs.

Because we have the size and the intellectual capital of our clinical enterprise that is in a regional basis and together with the intellectual capital and all the research and development and resources of Trinity Health, that's a national organization that's looking at all these quality initiatives, we're going to be working together in bringing people together on many, many clinical initiatives.

It's not just -- it's hard to say, you know, just one. There are many clinical initiatives, where we will get synergies, and we will be able to become more efficient and effective and raise the bar on creating standards of care.

So what we're going to be doing is are standardizing and taking variation out of the system and

creating a greater opportunity to really provide the utmost care, so, for example, we have three bariatric programs currently in our region.

They're all independent. They all have their own individual standards of care, and what we're doing are pulling together leadership in those, as an example, in that clinical entity, and all of those individuals will be looking at and fostering and developing what's the best clinical programming as a system and raising the bar and saying this is a better way of taking care of those bariatric patients.

For example, we may not need three centers. Maybe it will be better to consolidate some of those operations and just do them in Waterbury or whatever we believe, but the opportunity is to bring all those people together and really use their expertise and clinically develop those types of initiatives.

We can have other people to even address that. I don't know if you would want to, or maybe Dr. Silverman, or others may want to comment on that.

MR. HARTLEY: Chris Hartley. If you refer to page 1027 and 1028 of the application ?? there we list some of the ways in which working with Trinity will bring additional quality initiatives ??

1 One of the things Trinity has is the
2 universal -- there's a clinical access system that we use
3 as part of our organization that basically sets standards
4 for physicians' care across all of our system, uses
5 evidence-based practices to deliver that care.
6 We see that employed also through our
7 clinical service centers of excellence that will manage
8 to map those centers of excellence with those at Saint
9 Mary's using standard protocols across all of our system
10 to ensure common clinical protocols and common treatment
11 as part of the program.
12 We also basically are going to be using
13 similar clinical protocols for all our physician groups
14 throughout the system, which ensures common treatment for
15 patients, as well as the same health information system
16 across all of our system, again, being able to move
17 patients within our system and keep the same medical
18 records and keep the information together for those
19 patients. It's part of our initiative to raise the
20 quality of care there.
21 Actually, this is a question that should
22 be answered by a clinician. I'm not a clinician, so,
23 Adam, Dr. Silverman, you may want to comment on this.
24 DR. SILVERMAN: Hi. Adam Silverman, Vice

President for Ambulatory Strategy at Trinity Health New England.

I think Mr. Hartley started to get into where I believe the real value of bringing Trinity Health to Connecticut and Western Massachusetts is really benefitting the patients through the clinicians on the ground, and part of that is this unified clinical organization that Mr. Hartley was describing, where, regardless of what program we're talking about, what we want to look for across our system and the real value of the system is to find what I'll call best in breed, so who is doing best in whatever program we're talking about.

It could be an open heart program. It could be an obesity program. It could be care of the elderly. How do we keep the older adult population living independently longer?

Up until now, it's been what locally we have in our own particular organizations that really have driven sort of either the evidence-based or, when the evidence is lacking, the best practice.

Now we have partners across the country in 22 states, who have struggled with the same thing. Some are a bit ahead of us, some are a bit behind us, and it

saves us from having to recreate the wheel, so we can bring that evidence-based or that best practice to bear more rapidly by being connected to this unified clinical organization for our physicians.

Rather than go program-by-program, it's who are the high-risk patients? Who are the ones that we need to identify today, who are going to be our patients tomorrow? How do we keep them healthier? How do we keep them out of the hospital? How do we keep them out of the emergency room? How do we reduce the cost and the time that they spend in the health care system, and how do we improve their overall well-being moving forward?

MS. RIGGOTT: Thank you.

MR. HARTLEY: Chris Hartley. Just one other thing to point out. This is multi-dimensional. Basically, we work with Trinity Health on the state and local basis on legislative changes that are necessary to encourage program development.

On Tobacco 21, for example, what we think is a best care scenario. Basically, we help to work passing an increase in the smoking age from 18 to 21. We didn't succeed this year, but that's part of Trinity's ongoing initiatives across the country, to move the tobacco age up, because there's evidence base that if you

move the age up for people to begin smoking, fewer people actually start.

We also work with obesity programs nationally, and we look at them locally to try to promote those programs, as well, as part of our evidence-based practice at reducing obesity, particularly in the poor populations, as a way to manage a variety of health issues, including diabetes, amongst others, so we're part of that.

We're part of a national what's called a Tiger Teams Initiative to expand access to behavioral health services nationally, on a national level and locally, to make sure that we have mental health parity for all patients and families in this community, so those are all initiatives that we work on, as well, as we work with Trinity to try to move those issues forward nationally and statewide.

MS. RIGGOTT: Thank you. My next question is for Mr. Wable. You mentioned in your pre-filed testimony via the transfer agreement that parties intend to reduce the cost of health care in the New England Regional Health Ministry service area and St. Mary's Waterbury service area.

Can you elaborate on how this is intended

to be accomplished?

MR. WABLE: Sure. I think there's probably multiple ways that this will be attended to. I think, first, on the local level, we're always looking at ways to be more efficient, through better productivity management, better management across the entire health system. That's the first and foremost, is what can we do locally?

Regionally, we're going to be able to then work together to figure out where there might be a certain amount of synergies where we can work better together.

An example of that is through supply chain alone, both on the regional and national level. Hopefully, we'll be able to buy products and services at a lower cost as a result of multiple parties working together to accomplish that. That's another example.

The third way will be best practices across all the different entities, so each one of us may take care of a surgical patient or a medical patient a little different than one another, being able to have forums, where physicians and clinicians and administrators can come together and learn what those best practices might be and roll those out within a

region or use national best practices to roll out where there have been either cost saving, evidence of cost savings nationally, or regionally, or otherwise, where we can continue to reduce cost, and I think, through all of those prongs, we will be able to reduce costs over time.

MS. RIGGOTT: Okay, thank you. My next question is regarding the makeup of the Board. In the application, it was stated that the New England Regional Health Ministry Board of Directors will appoint two members from the Saint Mary's community to the Board.

It's important to OHCA to have true community representation on the Board, and I'm wondering if there are alternatives to having community members selected by the Board.

We are most interested in someone, who can bring the community's concerns to the hospital and likewise bring hospital information to the community.

MR. DADLEZ: Well I'm sure you know that the organization is a community not-for-profit organization, and all the Board members that serve are volunteer Board members that are community representatives, so we think we do a great job in identifying individuals that represent the community.

We're really focusing on making sure that

they're reflective of the community and trying to get more minority representation and others on our Board, but we feel that those individuals that are currently in place and the potential folks that are coming on board do reflect and bring that community representation, so I'm not sure what other suggestions you might have, but we think that they're incredible advocates for their communities and have done a really outstanding job over the years representing the community, so we feel we're in good shape, but I don't know whether, you know, what, specifically.

MR. HARTLEY: I think it's evidenced by the public testimony and the letters that are in our application. There is no apparent concern about the level of representation we have provided to the community in the past. We're remaining not-for-profit.

We continue to provide plenty of access to our community health and needs assessment and other activities to services and needs in the community and will continue to do so.

MR. DADLEZ: We also have many other avenues of community representation. For example, our Curtis Robinson Center for Health Equity has a very comprehensive Advisory Board that brings together leaders

in the community that are really focused on health equity and their issues. All that information bubbles up to the regional Board. All our local Boards have community representation, that, in addition, they focus on the quality, on the immediate local needs of those communities.

All that information comes up to the Board, so one of the things of a well-functioning Board is not to have an overwhelming volume of people on it, because you'll never get anything done.

You want to have the correct number of folks on there and make sure that you're really implementing the strategic direction for the community, so you don't want to overwhelm it, you don't want to overburden it, but you want to make sure all the correct information comes up to the regional Board, and I think that we're doing a very good job at it right now in my estimation.

MS. RIGGOTT: Thank you. With respect to a three-year service plan, are there concerns regarding submitting to OHCA a plan describing any consolidation reduction, elimination, or expansion of existing services, or introduction of new services?

MR. HARTLEY: Chris Hartley, St. Francis.

I think the issue here is threefold. One, it is a health service. What is a health service, and what are we talking about, and, also, recognizing the dynamic nature of health care right now, projecting today, and we will be happy to commit to what we're providing services now.

Without taking into account the changes that are rapidly occurring in the health care system, the changes in reimbursement, and, actually, the changes in the way we deliver health care potentially could lock in place services without service change that are not appropriate to do at this point in time, but, clearly, our intention is to continue to provide health services in this community over the three-year time frame that's talked about, but there's nothing magic about three years.

The issue here is to make sure that we do care in the right place, the right way, at the right time, and that's going to change over time, and it's going to be focused more and more on prevention and maintaining the total health of a person over time, so, yes, the concern would be artificially locking in place an ill thought out definition of health services that doesn't give us the flexibility to change with the way health care, itself, is changing in a rapid fashion.

As you know, some of the things that we've talked about today, even the input of the Community Health Needs Assessment, isn't available at this point in time. When this is finished and available, there may be some new areas that identify for us as part of that.

Clearly, the reimbursement changes that are going on have impacts and pressures on all health care providers, and working with others in the collaboration may change the way we deliver that health care in the future, and we've got to look at that and think of that as we go forward together, but, clearly, our intention remains to provide the health services that we have today tomorrow, but perhaps in a different way, and we can't predict all those ways at this point in time.

MS. RIGGOTT: Thank you. Any my last question involves the capital investment plan. Are there any concerns with submitting to OHCA within a specified time frame a capital investment plan, detailing a list of planned capital expenditures with descriptions and associated estimated costs and time frames?

MR. BITTNER: I think, with -- David Bittner. I think that any capital planning I think both our organizations, St. Mary's and Trinity Health, Trinity

Health New England, try to plan out capital in a three-year, five-year kind of time frame, however, even in a single year, it's hard to predict that the capital that we planned this year for next fiscal year that we'll spend all that capital exactly how we've outlined, those capital spends.

I think we've provided to OHCA in a series of reports those kind of capital expenditures that we kind of foresee, in terms of facilities, equipment, technology, as well as other kind of future opportunities that we haven't identified what those opportunities are.

We have provided, I think, at least in the last, next couple of years related to capital, but, from the specificity around which pieces of equipment or which facilities are those that I don't think we have -- able to commit to, simply because even when we have a fiscal year budget over a 12-month period, those change on a month-to-month basis, depending on availability of capital, what's happening with funding from the state and the federal side, as well, which really has a place hold on what and how much capital you can spend in a fiscal year.

MS. RIGGOTT: Thank you.

MR. DAVID FERNANDES: Hello. My name is

1 David Fernandes. I'm part of the OHCA staff. My
2 questions will pertain to the intercompany system fees,
3 and my first question is going to be would it be accurate
4 to say that the incremental column within the financial
5 Worksheet A, as submitted in the pre-filed testimony,
6 does not include the Trinity Health New England
7 intercompany fees?
8 MS. SCHNEIDER: Jennifer Schneider. With
9 respect to the intercompany fees, there's a couple of
10 different components, and the first is the system
11 allocation, which is -- I think you've seen us reference
12 it. It's a .8 percent of total operating expenses.
13 When we show the incremental savings of
14 one percent, that was net of the 1.8, so those types of
15 corporate fees really are to support all the things we've
16 talked about here, evidence-based standards as we move
17 forward, and it really gives the ministries access to
18 those services and really that benefit.
19 There's another piece, as you see
20 reference in the definitive agreement and other places in
21 the submission, where it talks about shared services.
22 In those shared services, really we tap
23 into those. They're more direct expenses, so once we
24 start utilizing revenue cycle and other areas directly,

it's really, again, a one-for-one, so there's no incremental costs associated with either Trinity Health New England or Saint Mary's with respect to those, and those come on later, as we become more mature into Trinity Health and Trinity Health New England as the organizations move forward.

MR. FERNANDES: Thank you. My second question is can the Applicants at this time provide an estimated dollar amount for what the intercompany fee might be after the first year of the proposal?

MS. SCHNEIDER: So the intercompany fee, again, is the .8 percent of operating expenses, and it will be set at the Trinity Health New England level, so, you know, for Trinity Health New England, it will likely be about between eight and nine million for the entire system, and then it will be Trinity Health New England's responsibility to allocate that across all of the local hospitals and other entities within the organization.

MR. FERNANDES: Okay, thank you. Third question. Currently, what is Saint Mary's spending on the services that will now be covered by the intercompany fees?

MR. BITTNER: Well I think it's hard to quantify at this point, because there are certain I guess

operational costs that we just haven't been able to get to. Some of them are purposes for FTC reasons, but, as you look at Trinity's overall supply chain that Chad Wable had just mentioned, in terms of changing group purchasing organizations and having a group purchasing organization the size that Trinity Health has, bring supply chain savings to Saint Mary's, specifically, but, also, to Trinity Health New England.

In addition to that, they also maintain their own commercial insurance programs. Not only commercial insurance, but for property, casualty, general liability, malpractice. All those costs are self-insured by Trinity Health.

There's 90 hospitals with over $15 billion or $16 billion in revenue, so given that scope in size, so insurance costs related to Saint Mary's, supply chain costs, also treasury costs, when you start looking at cost of capital, the amount of investment return that one could have, when you're in a position like Trinity Health has been, St. Francis Care and Saint Mary's, as well, where you're subject to debt covenants around certain days cash on hand, you don't really have the luxury to invest a lot of your cash into the open market, because it doesn't -- it can't really suffice with the swings in

the market, so if you have an unrealized loss, it can put you in a position where now you no longer meet those covenants.

And, so, with Trinity Health, they actually put, they can actually put those investments in the market and earn an additional return, so it's not only a savings on expense perspective, but, also, it's beneficial interest or investment income that can be generated from the cash that's currently on hand at the respective organizations.

MR. FERNANDES: Thank you. My last question will be, other than the intercompany system fees, will Saint Mary's be required to make any other payment, either directly or indirectly, through the New England Regional Health Ministry to Trinity Health, Inc.?

MR. BITTNER: Well, at this time, there's no fees that I can tell you today that would occur and how some of those could change in the future.

I do think that, as we bring the region together, there will be shared services across the whole region, so there will be regional costs that will be held at Hartford, so revenue excellence, a revenue cycle, for instance.

What we're trying to work on is developing

a unified billing office, so if you're a patient, wherever you had gone within Trinity Health New England, you would get one patient bill for any service provided by any clinician, who is affiliated with our system, would go through a unified billing office, and that patient, then, is connected throughout the entire region through the electronic medical record.

So with that aspect, some of those services are corporate services, and those fees, then, would be charged up through the individual hospitals that they belong to, so Saint Mary's could have a regional fee, if you will, but all those fees would just be offset by the overhead cost reductions as the system kind of matures and achieves and climbs the scale throughout the region.

MR. FERNANDES: The billing service, is that included right now in the .08 percent?

MR. BITTNER: No, it's not.

MR. FERNANDES: So it potentially may be an increase, or there may be a potential like --

MR. BITTNER: There may be a price that goes, maybe a cost over to the regional system, but if you look at the cost currently for Saint Mary's to provide billing services, that actual cost would go down.

It would just be, instead of spending it on FTEs within the local area, it would be in a regional setting, so, actually, a reduction in the overall cost, itself, but it stays within the region.

MR. FERNANDES: Okay, thank you. That concludes my questions.

MR. RONALD CIESONES: Ron Ciesones, OHCA staff. My questions are going to start regarding some of the accounting methods and the financial stability of the organizations. They come from the interrogatories that were filed.

Regarding the statement of operations data for the first six months that were submitted with the pre-file, do you expect the financial performance would be similar in the second half of the year as with the first six months of activity?

MR. BITTNER: The short answer is, no, no. We expect operations to improve. September of 2015, the health system, both our health systems, actually, was really hit with the first kind of round of Governor Malloy's reductions and really forced us, and we at St. Francis Care had a budget ready to go in front of our Finance Committee.

We actually kind of tossed it. We kind of

restart the budget process over again, and that time that it took, basically, to respond to the reductions in reimbursement on the State and the Federal level I think took us at least that six months, and, as Chris has stated before and Chad, as well, what we've done is focus on productivity improvements, trying to look at the productivity of our staff, provide them tools and resources to better manage the staff and be able to flex up and down between where the volume is occurring with each of the patient floors.

That, and then working with Trinity Health to try to optimize some of the synergy, so it's taken us I think the first six months of the fiscal year to get in line a lot of those operating improvements and get in line some of the strategic initiatives that we wanted to put in place to make those improvements into the fiscal year, so that six months ending March we actually had significant improvements in our fiscal situation, were, actually, we had a $3 million gain as Trinity Health New England and then moving forward in the April, May, June, which completes the fiscal year for Trinity Health.

We expect the latter six months to improve significantly, and we're hopeful that we'll get the funding that the legislative body just approved in this

last special session back in December and, again, in May.

MR. CIESONES: Now your response is mostly regarding Trinity Health New England's piece, as to the finances?

MR. BITTNER: Yeah.

MR. BECKER: Ralph Becker. We are doing a little bit better this year than we have been. Volumes are up a little bit, so that's been helping, but do I see us doing as well in the last six months? Yes. I think we will continue doing as well as we are right now, again, subject to what happens with the provider techs.

MR. CIESONES: So would you say that the financial ?? that were submitted with the application would be accurate for the years 2017, '18 and '19, or would they need to be adjusted?

MR. BITTNER: That's our best estimate today. I think that assumes that we get some of the tax funding back that have been promised in the legislature, so, again, if the administration withholds the supplemental payments, so, for Hartford, for St. Francis, that's $40 million of taxes that we pay, so whatever supplemental payments we don't get, that kind of goes back into the overall tax, itself.

This assumes that we get at least what's

been estimated by the legislature, and it's our best estimate at this point in time.

MR. CIESONES: Throughout the application or the pre-file, rather, you, on pages 1025 and 1034, you reference cash flow from operations quite a few times for both St. Francis and Saint Mary's.

How come you use -- is there a reason that you use cash flow from operations, as opposed to operating income and losses from the statement of operations?

MR. BITTNER: Yeah, because the cash flow from operations kind of, before we actually make any kind of capital expenditures, so that's basically what the organizations bring in from a cash perspective before we actually expend it in other capital or other investments, so that's the indication of what we can generate just from an overall cash flow perspective.

MR. CIESONES: And would you be able to provide a supporting worksheet for the numbers that you have on both pages 1025 and 1034 for both St. Francis and Saint Mary's?

MS. SCHNEIDER: Jennifer Schneider. So you're just looking for supporting documentation to support those numbers?

MR. CIESONES: Right. There's St. Francis, 33.6 million.

MS. SCHNEIDER: We could provide that.

MR. CIESONES: Okay, thanks.

HEARING OFFICER HANSTED: Okay. I'll order that as Late File No. 1.

MR. CIESONES: My next question regards Saint Mary's pensions. That's noted throughout the pre-file. You noted that one of the -- once this was to go through, that you would like to bring the Saint Mary's pensions more -- fund more of the pensions, similar to Trinity. Do you have any procedures, methods to do that?

MR. BITTNER: I think there's an overall, I guess, philosophy, and that philosophy would be to fund it at the same levels as you mentioned before.

There's a lot of information that goes, a lot of variability that goes into that calculation, itself, so a discount rate, for example, so if you look at the current interest rate environment that we're in, it has a lot to do with what the overall pension obligation is going to be out in the future, so it has a huge impact on what the funding status is, so if you had a one percent increase in the discount rate, you could have an increase of funding status significantly just

from that one change in interest rate environments.

The second one is some of the demographic information related to the assumptions being used in the actuarial valuation, so a lot of those were just recently changed, both for Saint Mary's and organizations, I think, in the United States, actually, that has a significant impact on the overall pension obligation, how much that is.

The other piece is how well is the investments in the pensions doing within the market, itself. So if the market does significantly better than what your expectations are, then your funding status automatically goes up, without any additional contributions.

I guess, aside from that, there is an overall plan. Historically, Hartford has always funded the pension expense, and, so, that would be more of a minimum funding requirement from a personal perspective or how we kind of treat that historically, but anything above that we'd like to get to that 80 percent, plus, 80, 85 percent level of funding status, where, currently, at the end of FY '15, Saint Mary's was at 47 and a half percent.

And, so, that's both a combination of

change in discount rate, change in looking at the actual how the investment performance is doing, as well as contributions by Trinity Health, Trinity Health New England into the actual pension plan, itself.

MR. CIESONES: Do you see Trinity somehow taking a loan to bump up the funded status possibly?

MR. BITTNER: Possibly. That's always an option. That is one of which we're looking for with Trinity Health New England. With St. Francis Care, we're looking at a loan to help continue to fund our pension liability into the future, as well.

MR. CIESONES: The next couple of questions I have are regarding the capital commitment amounts for Trinity Health New England.

On page 1034, the previous responses indicate that the hospital spends roughly $12 million per year on capital expenditures or capital acquisitions, and Saint Mary's Health System projects to earn approximately 8 million per year from operations after the merger.

Why does -- considering that there will be a profit from operations, why does Trinity have to contribute the 54.7 million for Saint Mary's?

MR. BITTNER: A big portion, I think, of that, the $45.3 million is over a series of time, so,

over the five-year period, it's expected that there will be an operating income, which is that 45.3, so there's a $100 million commitment. The difference, then, is that 54.7, so what's hard to predict, in terms of either whether we forecast something two years out or three years out, is what's going to happen on a federal and state reimbursement perspective?

It's hard to predict, and I think, to a certain degree, as we try to even budget for even this year and last year, St. Francis I can speak for had made commitments to its employees to increase its across the board living adjustments.

We make commitments to fund defined contribution plans, of which, because of the promises that were made around the supplemental payments and the supplemental pools around the provider tax, itself, we made those commitments, but, then, once those were pooled, we still honored those commitments, knowing that there may be opportunities where the legislature comes back, and I think in this case, as well, I just look at the 45.3 million, some of the 54 that's got to be funded through intercompany debt is because it's anticipated that there are going to be issues, I think, on the state side, as well, and federal reimbursement, for that

matter.

MR. CIESONES: Also, on page 1034, will the operating losses that thus far in fiscal year 2016 for Trinity affect the funding for St. Francis' $158 million contribution from operating income from the same chart?

MR. BITTNER: Could you repeat that?

MR. CIESONES: On the chart, you have 158 million for St. Francis.

MR. BITTNER: In expected operating.

MR. CIESONES: Right.

MR. BITTNER: Right.

MR. CIESONES: On the financials that you submitted with the pre-file for the first six months shows Trinity Health with an operating loss of roughly 16 million?

MR. BITTNER: Right.

MR. CIESONES: Will that affect the $158 million commitment, the commitment that comes from operating?

MR. BITTNER: No. So, first of all, I'll just kind of mention, when St. Francis and Trinity Health got together, there was a $275 million kind of commitment over a five-year period of time.

You kind of see the breakout is 1,033, how we're looking at that 275 million amongst, and it has given us opportunities with Saint Mary's, Johnson Memorial Medical Center to kind of come together in this regional health system, so if Hartford, if St. Francis Care does not perform financially, then more money, then, would come from Trinity Health, in order to fund that commitment versus the funding of the commitment coming through hospital operations through income from operations.

I don't expect -- I think the 158 million is our best estimate of what our cash flow income is going to be over the next five years, considering what's happened with reimbursement, and that's kind of our best guesstimate.

It wouldn't impact, then, if we had losses, it may impact where we'd get more money from Trinity. If we got higher, the less money that we have to borrow from Trinity from a capital commitment perspective.

MR. CIESONES: I just have one last question. Would the operating revenues from one of the hospitals, whether it's Johnson or Saint Mary's, be used to fund capital improvements at another regional health

ministry hospital?

MR. BITTNER: Within Trinity Health New England? Are you asking if it could?

MR. CIESONES: Yes.

MR. BITTNER: Yes, it could.

MR. CIESONES: So money can kind of flow in between the three hospitals?

MR. BITTNER: Yeah. If one hospital is much more successful than another hospital, then definitely, if there's a need from a community perspective, then that hospital would have the funding it needs to support those programs and services, and one of the pillars I think Trinity Health has and Trinity Health New England is commitment to those, who are poor, and, so if one hospital is struggling to fulfill that commitment and the other one is doing very, very well, then some of that operating income would go to actually improve the other's performance and continue those other services.

MR. CIESONES: So the three will kind of all be working together?

MR. DADLEZ: Well you're seeing that right now, for example, at Johnson Memorial. We're providing substantial support to Johnson right now while it's getting its feet on the ground and restructured, so,

1 obviously, that has to happen.
2 When we're trying to do is evolve from
3 this old school hospital enterprise to a total health
4 care operating company that's responsible for developing
5 the right services in the right place at the right time
6 for the entire region, so we'll be investing in
7 ambulatory care development that might be between
8 Hartford and Waterbury. We'll be investing in ambulatory
9 development between ourselves and Johnson Memorial.
10 So the whole world is changing, and how we
11 invest our dollars is really focused at how do we create
12 the best system we can for the people that we serve?
13 And, so, it will be somewhat fungible, but
14 we want to take care of the locations, because the
15 hospitals right now, you know, they have to be successful
16 and drive a lot of business, but we're trying to evolve
17 in this case, and capital investment is going to depend
18 on how the whole health care enterprise evolves, if that
19 makes sense.
20 MR. CIESONES: That's all I have for
21 questions.
22 HEARING OFFICER HANSTED: Before OHCA
23 continues with its questions, I understand we have a
24 senator that would like to give public comment.

(Whereupon, Joan Hartley gave public comment.)

MS. SCHAEFFER-HELMECKI: Hi. Good afternoon. So I'd like to ask a few more questions about the capital commitment and, specifically, how you expect it to be apportioned among the different regional health ministry entities.

And, as a basic question, firstly, are the amounts of capital expenditure allotted to each hospital maximums or minimums?

MR. BITTNER: Minimums.

MS. SCHAEFFER-HELMECKI: Now during the public hearing associated with St. Francis' application, 15-31979-CON, Trinity stated that at least 195 million of the $275 million pool of capital expenditures would be committed to St. Francis Hospital, specifically. Is that correct? I believe it was actually your testimony, Ms. Schneider.

MS. SCHNEIDER: Well I have to locate it.

MS. SCHAEFFER-HELMECKI: It was on page 33 of the transcript. I believe it was the portion that we took administrative notice of.

MS. SCHNEIDER: That's correct. So if you note there, it says 195, specific to St. Francis Hospital

capital acquisitions, whether it's upgrade to facilities, medical appointment, other areas that have been identified.

And I think, when we speak about, you know, the upgrades and the capital acquisitions, that can be inclusive of the St. Francis system.

MS. SCHAEFFER-HELMECKI: Okay and I believe you later said that it was specifically for entities already affiliated with St. Francis on that July 1, 2015 hearing, although there was 48 million allocated for other future associations.

MS. SCHNEIDER: Correct. That is correct.

MS. SCHAEFFER-HELMECKI: Great. So, in your responses to the completeness questions, you also stated that, at the time of the St. Francis hearing, again, July 1st, that you knew Trinity and Saint Mary's would seek to merge.

That being said, why has St. Francis' capital commitment been reduced from 195 million to possibly 142 million?

MS. SCHNEIDER: So I think, again, to David's point earlier, it's the minimum capital commitment, and I think it's really the 162 million is specifically a minimum to St. Francis. Oh, sorry. Page

1034.

MS. SCHAEFFER-HELMECKI: Excuse me. What was that on page 1034?

MS. SCHNEIDER: 1034, up at the top, the total capital expenditures, total funding. We were asked, I think, to show, to demonstrate how the 275 could be allocated, and we talk about the 100 million minimum to Saint Mary's, 13 million to Johnson, and 162 million to St. Francis, and, again, these are the minimums.

MS. SCHAEFFER-HELMECKI: Maybe I misunderstood, but I thought that was the source of the funding, where the money was coming from, not where the money was going on page 1034, so are you referencing 1033?

MS. SCHNEIDER: Correct. Which rolls over to 1034.

MR. BITTNER: Let me just mention, so, when Trinity Health and St. Francis Care came together, it formed Trinity Health New England, and, so, a $275 million capital commitment went to Trinity Health New England, of which then it's utilized to that capital commitment to help with the acquisition of Johnson Memorial Medical Center on January 1, 2016, and then now, as Saint Mary's have come together, it's provided the

1 necessary capital to provide a commitment.
2 St. Francis Care on its own wouldn't have
3 the ability to be able to commit those kind of funds
4 without a partner like Trinity Health, so that 275 was at
5 Trinity Health, so St. Francis Care on October 1st became
6 Trinity Health New England.
7 MS. SCHAEFFER-HELMECKI: So you're saying
8 there was no money allocated to a specific entity, and
9 you're saying it was just a general pool of 275, and the
10 allocation that was submitted as part of the application
11 was not indicative of how the money was actually to be
12 spent?
13 MR. BITTNER: No. The 275 was allocated
14 to Hartford within Trinity Health. It formed Trinity
15 Health New England, so Trinity New England then became
16 the entity in which, for the Hartford office, then, of
17 which it could spend or have commitments of that 275
18 million over a five-year period of time.
19 MS. SCHAEFFER-HELMECKI: But at the time
20 of the application, St. Francis Hospital was St. Francis
21 Hospital, so references to money allocated to St. Francis
22 Hospital was the hospital and not St. Francis Care or
23 what is now the Regional Health Ministry, correct?
24 MR. BITTNER: Correct.

MS. SCHAEFFER-HELMECKI: Okay, great. All right, so, just to return to that $48 million, that was unallocated originally, so, at the time, you did state that you believe that Johnson's capital expenditures would probably come out of that 48 million, as it was an organizational priority, correct?

MS. SCHNEIDER: That is correct.

MS. SCHAEFFER-HELMECKI: And then, also, you stated that St. Francis, so, like you anticipated the Saint Mary's merger, and I still am not seeing exactly why there wasn't money allocated in that 48 million for Saint Mary's, because now we're looking at a capital expenditure for other entities of between 113 million and 133 million, which that seems like a fairly significant departure from the 48 million that you had set aside originally, so I don't understand. I guess I'm not seeing why there wasn't more money set aside.

MS. SCHNEIDER: I think, at that point, it was really the timing and where we were in the maturity of the discussions with Saint Mary's, in terms of being able to specifically allocate anything at that point in time.

MS. SCHAEFFER-HELMECKI: So now the change in the Saint Francis, excuse me, Saint Francis Hospital

allocation is about between 65 and 85 million difference than what was initially projected to be spent on capital there.

What projects, if any, will be eliminated or modified at St. Francis as a result of that change?

MS. SCHNEIDER: I think, going back to David's point around our capital strategy, we really look at three years. We try to plan three years. It's even difficult, so there's nothing that we're aware of that would not happen.

And, again, this is the minimum commitment, as we continue to identify strategic initiatives and necessities within the local hospitals that are part of the ministry.

Those would be our priorities, and if we needed access to capital, we would, then, move forward as part of the capital management process within Trinity and see if we could get funding for those if our operating income and our current cash flows could not support that, but there's nothing, I think at this point, that I'm aware of that would be delayed or not fulfilled, based on any of these changes, specific to St. Francis Hospital.

MS. SCHAEFFER-HELMECKI: And at what point would you know what the capital expenditure plan is at

1 St. Francis if anything is changing?
2 MS. SCHNEIDER: So we are in the process
3 of doing our capital budget right now for fiscal '17,
4 which we will manage and report I think as of July 1
5 fiscal year, and, at this point, everything that's
6 included in our capital plan is going to, you know,
7 Trinity Health for insurance.
8 It's aligned with the strategy, and we
9 would hear, and we don't believe, and we've heard nothing
10 to lead us to believe that that wouldn't continue to be
11 our plan for fiscal '16. '17.
12 MS. SCHAEFFER-HELMECKI: So, now, if there
13 are any additional entities that are acquired by Trinity
14 in the future that become part of the Regional Health
15 Ministry, would that in any way alter the amount
16 available to Saint Mary's for capital expenditures?
17 MR. BITTNER: I think that the 100 million
18 or 120 million, depending on how Saint Mary's performs,
19 there may be opportunities that Saint Mary's finds within
20 the community within Waterbury for investment
21 opportunities that may go against that $100 million.
22 So, if you look at their current
23 operations now, there's a lot more investments that have
24 to occur, I think, in the future, whether that's the

acquisition of ambulatory strategies ?? the community.

That could further -- I mean that's an investment of capital, right? So that goes against the $100 million, I guess you'd say, if it's related to the ambulatory strategy around the Waterbury market.

So I think, from a capital perspective, we tend to look at this from a more global perspective around Trinity Health New England and the region and how we provide health care services around the region, as well.

I can say that, as we mentioned before, these are minimum requirements, so if there's opportunities within the state, within the region that are good opportunities from an economic perspective, that those would be funded by Trinity Health, but those go to a separate Board at Trinity Health or a separate committee, of which Chris sits on, as well, that helps to allocate the overall resources that Trinity Health has from an investment perspective.

MS. SCHAEFFER-HELMECKI: So that's a, yes, it could change, but it's a minimum? You're saying that 100 million is an absolute floor, and regardless of any entities acquired in the next five years, there's a guaranteed $100 million commitment?

MR. BITTNER: Correct.

MS. SCHAEFFER-HELMECKI: Okay, thank you. Okay, I have just one last set of questions. Prior to Trinity's acquisition of St. Francis, how much was St. Francis spending each year on average on capital investments.

MS. SCHNEIDER: Between 35 and 38 million on average prior to. The more recent years were a little bit higher with our investment in the Epic implementation, so prior to those two years, it's probably closer to 30 million, but, more recently, about 35 to 38.

MS. SCHAEFFER-HELMECKI: Yeah. I think we had 39, the number that had been stated several times, so that seems accurate.

Based on your projections of spending between 142 and 162 million in capital at St. Francis over the next five years, that works out to an average of between 20.4 million and 32.4 million per year.

Are you projecting a decline in capital spending at St. Francis compared to its spending prior to joining Trinity?

MS. SCHNEIDER: No. Again, that would be the minimum, and the budget currently, going into fiscal

'17, is just under 40 million as it stands today. Again, there's a lot of regulatory pressures and other financial issues we're dealing with, so it's not approved yet, but it's higher.

MR. DADLEZ: An example of that is, because we keep stressing minimum, minimum, I mean this is the bottom threshold, in the Springfield market, for example, which doesn't deal with Connecticut, Trinity just funded the purchase of a 200-member physician group, River Bend Physician Group in that region, and over and above, way over and above the capital commitments that is made on an annual basis to assistance of Providence health system, so the commitment is to do what's right for the community, and if there are opportunities to develop and grow, Trinity's commitment is to fund that.

We're very quickly becoming one of the largest, if not the largest regional ministry in the nation, and they want us to grow and develop.

The intent is for us not to squeeze dollars out of this region, but to strategically grow it and make it stronger, so I frankly and firmly believe that there's a commitment to do more, not less, so, in my mind, there's no way that it will be less than what we've traditionally spent.

MS. SCHAEFFER-HELMECKI: Okay, great. Thank you.

MR. DADLEZ: Okay.

HEARING OFFICER HANSTED: All set? Okay. That concludes OHCA's questioning.

At this point, I want to ask one more time is there anybody here that would like to give public comment that has not had an opportunity to do so?

I don't hear or see anyone. It's only 5:30 at this point. What I'd like to do is give members of the public an opportunity to get out of work and actually travel here, if they choose to do so, so we will adjourn until 6:00 p.m.

At that time, we'll go back on the record to see if there's any more public comment, so, at this point, we're adjourned until 6:00 p.m.

(Off the record)

HEARING OFFICER HANSTED: Okay, we're back on the record. It's now 6:00 p.m. One last time, is there anybody here that would like to give public comment on the proposal before us?

Hearing and seeing none, I would like to thank everyone for attending, and this hearing is adjourned.

(Whereupon, the hearing adjourned at 6:00 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 18th day of May, 2016.

Paul Landman
President

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## Greer, Leslie

**From:** Schaeffer-Helmecki, Jessica
**Sent:** Tuesday, May 17, 2016 8:09 AM
**To:** Hansted, Kevin; Riggott, Kaila; Fernandes, David; Ciesones, Ron
**Cc:** Greer, Leslie; User, OHCA
**Subject:** FW: 15-32045-CON Saint Mary's Late File
**Attachments:** Late File DN 15-32045-CON.pdf; 15-32045 Late File Last 12 months EBIDA.xlsx; 15-32045 Late File St Mary proj cash flow.xlsx

---

**From:** Capone, Claudio [mailto:Claudio.Capone@TrinityHealth-NE.org]
**Sent:** Monday, May 16, 2016 1:28 PM
**To:** Schaeffer-Helmecki, Jessica
**Cc:** Hartley, Christopher; Rotavera, Liz; Attorney Bob Anthony; Joseph Connolly - St. Mary's Hospital (jconnolly@stmh.org); Schneider, Jennifer
**Subject:** 15-32045-CON Saint Mary's Late File

Hello Jessica…Attached are pdf and excel documents in response to the late file request from the Saint Mary's and Trinity Health – New England May 10th public hearing.

Regards,


**Claudio A. Capone, FACHE**
Regional VP of Business Development and Strategic Planning

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Trinity Health - New England
15-32045 Late File
Last Twelve months EBIDA Calculation (Cash Flow from Operations)

**Saint Francis/Trinity Health - New England**

| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Last 12 Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Net Revenue | 70,908 | 68,835 | 67,628 | 73,123 | 65,819 | 66,555 | 70,731 | 67,707 | 70,228 | 71,812 | 63,916 | 81,047 | |
| Operating Income | 1,943 | 664 | (3,149) | 3,583 | (1,341) | (5,335) | (37) | (4,928) | (4,938) | (4,977) | (4,540) | 2,908 | |
| Excess Rev over Exp | 2,349 | 1,499 | 7,607 | 3,847 | (2,439) | (15,682) | (2,748) | (4,132) | (5,365) | (4,675) | (5,120) | 5,212 | |
| EBIDA | 6,057 | 4,898 | 1,093 | 7,827 | 2,883 | (1,012) | 4,107 | (733) | (816) | (598) | (362) | 10,208 | **$ 33,552** |
| EBIDA Margin | 8.54% | 7.12% | 1.62% | 10.70% | 4.38% | -1.52% | 5.81% | -1.08% | -1.16% | -0.83% | -0.57% | 12.60% | |

**Saint Mary's**

| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Net Revenue | 25,399 | 24,762 | 26,024 | 23,996 | 22,395 | 22,894 | 25,030 | 23,818 | 25,404 | 26,825 | 27,089 | 28,303 | |
| Operating Income | 539 | 283 | 1,500 | (859) | (1,052) | (358) | (594) | (443) | 1,637 | 925 | 203 | 1,967 | |
| Excess Rev over Exp | 578 | 519 | 1,846 | (386) | (550) | (1,646) | (631) | (492) | 2,404 | 772 | 339 | 1,807 | |
| EBIDA | 1,608 | 1,278 | 2,361 | 151 | (26) | 869 | 416 | 615 | 2,714 | 1,960 | 1,239 | 2,985 | **$ 16,172** |
| EBIDA Margin | 6.33% | 5.16% | 9.07% | 0.63% | -0.12% | 3.80% | 1.66% | 2.58% | 10.68% | 7.31% | 4.57% | 10.55% | |

**Total**

Source: internal financial statements.

Saint Mary's Health System
Future Cash Flows for Capital Acquisition after Debt Service
# 15-32045 Late File

| | (4) | (7) | (10) |
|---|---|---|---|
| | FY 2016 Projected With CON | FY 2017 Projected With CON | FY 2018 Projected With CON |
| Per Worksheet A Page 1012 of CON EBIDA | **$16,299** | **$18,755** | **$21,087** |
| | **5.4%** | **6.0%** | **6.6%** |
| Less: Principle Payments (Line 33 of worksheet A) | $3,000 | $3,000 | $3,000 |
| Cash available for Capital Acquisition after debt payments | **$13,299** | **$15,755** | **$18,087** |
| **Amounts reported on page 1025 of CON** | **$13.3** | **$15.6** | **$18.1** |

## Greer, Leslie

**From:** Schaeffer-Helmecki, Jessica
**Sent:** Wednesday, June 01, 2016 8:53 AM
**To:** Attorney Bob Anthony; Hartley, Christopher
**Cc:** Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
**Subject:** 15-32045 Close of Hearing
**Attachments:** 15-32045 Close of Hearing signed.pdf

Good Morning Mr. Anthony and Mr. Hartley,

Attached please find official notice of the closure of the public hearing held on May 9, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

**Jessica Schaeffer-Helmecki, JD, MPA**
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

*Office of Health Care Access*

June 1, 2016

VIA EMAIL ONLY

Mr. R. Christopher Hartley
Senior Vice President
Trinity Health – New England, Inc.
114 Woodland Street
Hartford, CT 06105

Mr. Robert Anthony
General Counsel
Saint Mary's Health System
56 Franklin Street
Waterbury, CT 06706

RE: Certificate of Need Application; Docket Number: 15-32045-CON
Transfer of Ownership of Saint Mary's Health System to New England Regional Health Ministry
Closure of Public Hearing

Dear Mr. Hartley and Mr. Anthony:

Please be advised, by way of this letter, the public hearing held on May 9, 2016, in the above referenced matter is hereby closed as of June 1, 2016. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Jessica Schaeffer-Helmecki at (860) 509-8075, Ronald Ciesones at (860) 418-7030, or David Fernandes at (860) 418-7032.

Sincerely,

Kevin T. Hansted
Hearing Officer

KTH:jssh

## Greer, Leslie

**From:** Hartley, Christopher <CHartley@stfranciscare.org>
**Sent:** Wednesday, June 01, 2016 8:54 AM
**To:** Schaeffer-Helmecki, Jessica; Attorney Bob Anthony
**Cc:** Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
**Subject:** RE: 15-32045 Close of Hearing

Thank you for your help in this important endeavor.

---

**From:** Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
**Sent:** Wednesday, June 01, 2016 8:53 AM
**To:** Attorney Bob Anthony; Hartley, Christopher
**Cc:** Greer, Leslie; Hansted, Kevin; Ciesones, Ron; Fernandes, David; Riggott, Kaila
**Subject:** 15-32045 Close of Hearing

Good Morning Mr. Anthony and Mr. Hartley,

Attached please find official notice of the closure of the public hearing held on May 9, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

**Jessica Schaeffer-Helmecki, JD, MPA**
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
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## Greer, Leslie

**From:** Greer, Leslie
**Sent:** Wednesday, July 27, 2016 4:08 PM
**To:** 'BAnthony@Stmh.org'; Hartley, Christopher (CHartley@stfranciscare.org)
**Cc:** Schaeffer-Helmecki, Jessica; Fernandes, David; Ciesones, Ron; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
**Subject:** DN: 15-32045-CON Agreed Settlement
**Attachments:** 32045 Agreed Settlement.pdf

Attached is the Agreed Settlement for DN: 15-32045-CON.

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
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

## Department of Public Health
## Office of Health Care Access
## Certificate of Need Application

## Agreed Settlement

**Applicants:**

**Saint Mary's Health System, Inc.**
**56 Franklin Street**
**Waterbury, CT 06706**

**Trinity Health Corporation**
**20555 Victor Parkway**
**Livonia, MI 48152**

**Trinity Health–New England, Inc.**
**114 Woodland Street**
**Hartford, CT 06105**

**Docket Number:** **15-32045-CON**

**Project Title:** **Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health–New England**

**Project Description:** Saint Mary's Health System, Inc. ("SMHS"), Trinity Health-New England, Inc. ("TH-NE") and Trinity Health Corporation ("THC"), herein collectively referred to as the ("Applicants"), seek authorization to transfer ownership of SMHS and its subsidiaries to THC and TH-NE.

**Procedural History:** The Applicants published notice of their intent to file a Certificate of Need ("CON") application in the *Republican American* (Waterbury) on October 22, 23 and 24, 2015. On November 25, 2015, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project and deemed the application complete on April 5, 2016.

On April 18, 2016, the Applicants were notified of the date, time, and place of the public hearing. On April 20, 2016, a notice to the public announcing the hearing was published in the *Republican American*. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on May 9, 2016.

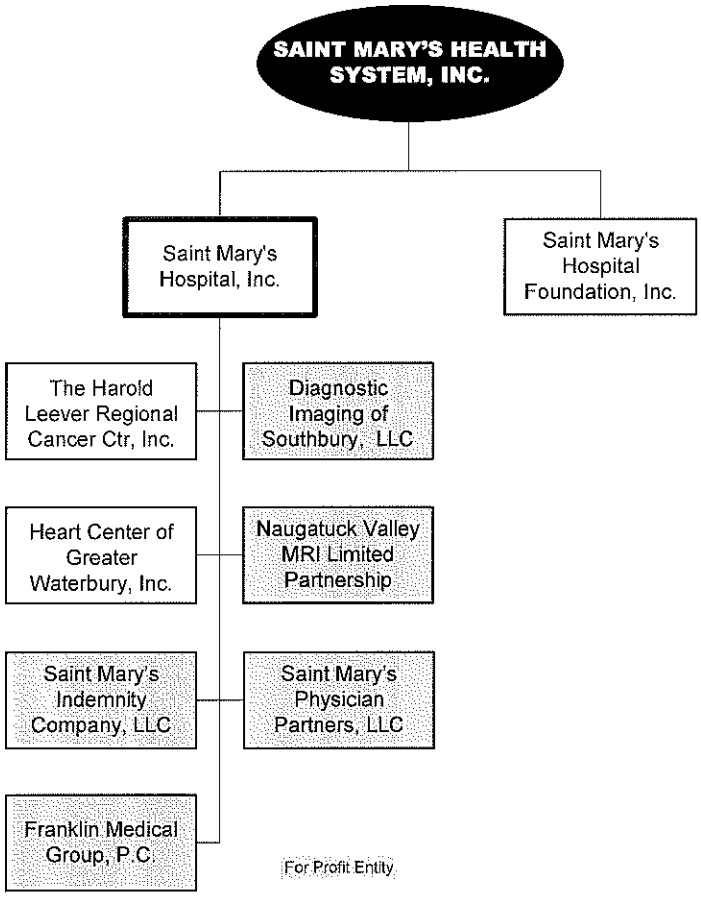
Attorney Kevin T. Hansted was designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a.

The record was closed on June 1, 2016. Deputy Commissioner Addo considered the entire record in this matter.

# Findings of Fact and Conclusions of Law

1. SMHS is a not-for profit, integrated Catholic health care delivery system serving the greater Waterbury area. Ex. A, p. 18.

2. SMHS is the parent company of Saint Mary's Hospital, Inc. ("Hospital"), and various other subsidiaries and affiliated entities (see legal chart of corporate structure, below). Department of Public Health, Office of Health Care Access, 2015, *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2015*; Appendix AA.




3. The Hospital is a 347-bed Catholic acute care hospital. It is designated as a Level II Trauma Center and provides a full range of inpatient, outpatient and ancillary services to residents of Waterbury and surrounding towns. Ex. A, p. 18.

4. The Hospital's primary service area is comprised of 16 towns. The Hospital's service area will remain the same as a result of this proposal. Over half of all inpatients in fiscal year (FY) 2015 were Waterbury residents (see table below).

**TABLE 1**
**SAINT MARY'S HOSPITAL FY2015**
**PRIMARY SERVICE AREA TOWNS**

| Primary Service Area | |
|---|---|
| **Town*** | **Discharges (FY 2014)** |
| Waterbury | 58.75% |
| Naugatuck | 9.18% |
| Wolcott | 6.25% |
| Prospect | 3.34% |
| **Total** | **77.52%** |

*Listed in descending order of discharge volume.
Ex. A, pp. 32-33; Ex. A, p. 289.

5. In anticipation of health care industry changes and federal health policy and reimbursement reform, SMHS's 2016-2020 Strategic Plan emphasized a shift from a fee-for-service structure to an accountable care organizations ("ACO") focused on population health management. SMHS determined that a strategic partner would bolster its ability to effectuate its Strategic Plan. Ex. A, pp. 22-23.

6. The need to address the following factors also prompted the Hospital to seek a partnership with another health care system:
   - Increased costs associated with quality improvements,
   - The growth of physician partnerships and the need for additional expertise in the management, staffing, data analysis and clinical oversight of a larger physician enterprise,
   - Necessity of expertise in clinical service redesign to utilize the latest clinical techniques,
   - SMHS's intent to expand upon its integrated accountable care organization
   - The financial capital required to meet the medicals records standard of the Patient Protection and Affordable Care Act ("PPACA"),
   - Development of a plan to address pension and other debt obligations, and
   - An aging infrastructure and the need to provide health services to the community as reflected in the Community Health Needs Assessment ("CHNA").

   Ex. A, pp. 22-24; Ex. E, p. 874; Ex. L, pp. 1026-1032.

7. SMHS created the SMHS Board-Appointed Taskforce ("Taskforce") more than a decade ago to assess potential partners based on a set of criteria including each candidates philosophical principles and adherence to a complementary set of religious directives; financial strength and ability to assist in satisfying SMHS's pension liability; provision of resources to improve technology at SMHS; and opportunities to recruit and retain staff. Ex. A, pp. 26-27; Ex. L, Prefile Testimony of Robert Mazaika, Chairman of the Board, SMHS, pp. 1062-3.

8. SMHS found THC and TH-NE to have a strategic plan and values very similar to its own, while sharing a common vision, philosophy and mission that preserves the Catholic health care tradition. Ex. A, pp. 22-23; 27.

9. Following the recommendation of the Taskforce, SMHS's full board approved a strategic alliance and a membership transfer agreement was signed on September 19, 2015. Ex. A, pp. 22-23; 27.

10. As a result of this agreement, the Applicants are requesting approval to transfer ownership of the Hospital and its subsidiaries to THC in order to become part of TH-NE. Ex. A, pp. 20, 27.

11. THC is a Catholic health care system with 88 hospitals, 126 continuing care facilities, home health and hospice programs across 21 states. It is the sole shareholder of TH-NE. Ex. A, p. 19.

12. TH-NE is the parent company of other health care facilities in Connecticut, including Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford. Docket Number 15-31979-CON. Ex. A, p. 19.

13. The focus of TH-NE's organizational structure is to create a system that meets PPACA's objectives of improving population health, enhancing the patient care experience and controlling cost, while maintaining a positive financial margin. Ex. A, p. 24.

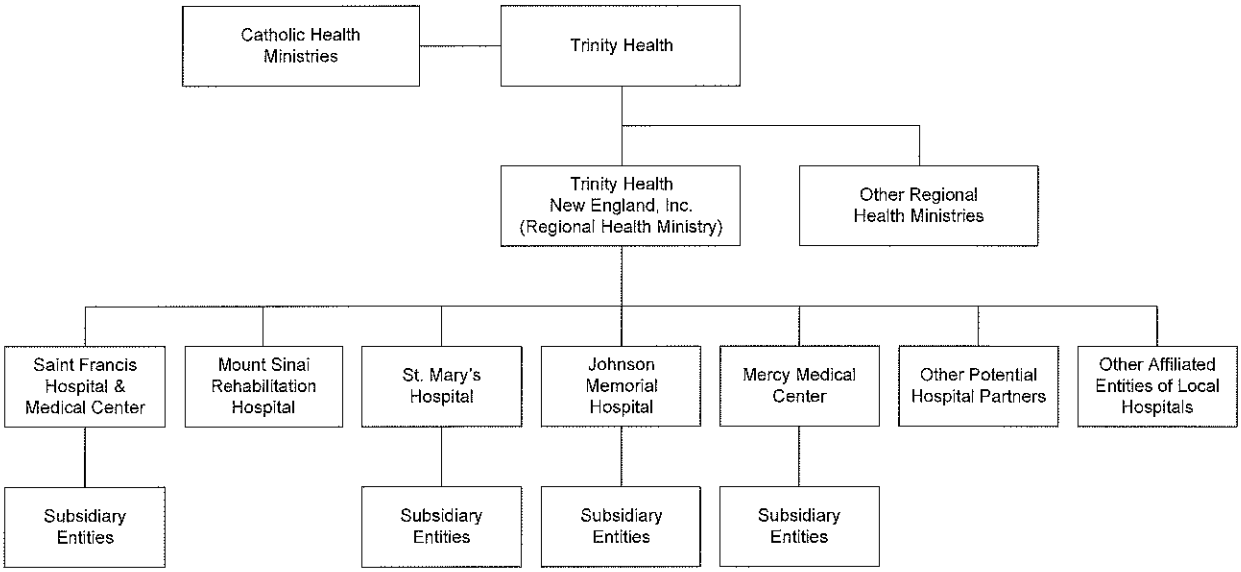
14. THC's key growth initiatives aim to align with organizations to strengthen the Catholic health care mission and to expand the system "footprint" to create an integrated ACO in each of its markets. Ex. A, p. 20.

15. THC has established a Unified Clinician Organization ("UCO"), a data and evidence-based infrastructure to align and support clinicians across the THC system, in an effort to advance a culture of safety, best practices, quality, patient satisfaction and high reliability. THC's accomplishments as a result of implementing its UCO initiatives include:
    - Decrease in sepsis mortality rate from 15.8% to 11.2% between FY 2010 and December 2014, resulting in 2,328 saved lives;
    - Elimination of vaginal birth after cesarean section "serious reportable events" following 2009 policy implementation;
    - Decrease in elective deliveries before 39 weeks from 4.7% from 2010 to 0.5% in 2015;
    - Consistent medication reconciliation composite score (both admission and discharge data) of 88% in FY 2015 to date;
    - Decline in pressure ulcer rates from 3.8% in FY 2008 to 0.01% in January 2015;
    - Lower than expected severity adjusted mortality rate (83%) in FY 2015;
    - Elimination of retained sponges in FY 2014 post-sponge accounting implementation; and
    - Improvement in safety checklist perfect patient score from 48% in January 2013 to 81% in July 2014.

    Ex. A, pp. 44-46.

16. To combat the substantial costs of hospital readmission, THC developed a post-acute care affiliated network that links a hospital to the continuum of post-acute providers. The result was a more accurate and efficient transition of patients from the hospital to the next level of care reducing readmission. Ex. A, pp. 52-53.

17. It is anticipated that SMHS will be dissolved, leaving the Hospital as the surviving entity. The following illustration depicts the organizational chart of the Applicants following the proposed transaction.




Ex. A, p. 163; Ex. E, p. 865.

18. SMHS's existing Bylaws and Certificate of Incorporation will be amended and restated so that TH-NE is the sole corporate member of the Hospital and the Hospital will be a direct subsidiary of TH-NE. Ex. A, pp. 20, 112.

19. The Applicants propose adding two board members, appointed by THC for a period of three years to the TH-NE Board of Directors. The Hospital's governing board will remain unchanged other than the addition of the CEO of TH-NE. The governing board of the Hospital will be comprised of:
    - A representative of the member, designated by the member;
    - At least one physician; and
    - Members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community.

    Ex. A, pp. 20-21; 70-71; 113; Ex. E, pp. 900-901.

20. The Hospital's board will have community representation that will have the ability to pass on quality concerns and local community health needs to the regional governing board. Testimony of Mr. Dadlez, Ex. N, pp. 40-41.

21. There are no planned changes to the clinical services or location of any clinical services currently being offered by the Hospital. However, following implementation of the proposal, an "efficiency analysis" will be conducted to assess whether the Hospital's current clinical practices are consistent with those of THC's in an effort to standardize the processes. Ex. A, pp. 21-22; Ex. E, p. 875.

22. For three years following implementation of the proposal, the existing SMHS Board's approval will be required prior to the termination or material reduction of any existing clinical services. Ex. A, p. 16.

23. The proposal does not involve any new equipment. There is no capital cost associated with the Transfer Agreement between the Applicants. Ex. A, pp. 21-22; Ex. E, p. 875.

24. The affiliation with TH-NE is intended to allow the Hospital to access experts in all clinical service lines and support platforms, and enhance its service delivery approach and systems. Ex. A, p.41.

25. The partnership between the Hospital and THC is also expected to result in access to resources of a large system at both the regional and national levels which will:
    - Help develop more preventive and primary care service programs, the need for which is identified in the 2014 CHNA;
    - Meet the demands of the 2010 PPACA, which requires an emphasis on value rather than volume in terms of reimbursement;
    - Provide access to readily available capital and financing at favorable interest rates; and
    - Assist in developing a plan to adequately fund SMHS's pension plan obligations. Ex. A, pp. 24-25.

26. The Health Resources and Services Administration has designated Central Waterbury as a medically underserved area and medically underserved population. Ex. A, p. 35.

27. TH-NE's CHNA and Strategic Implementation Plan ("SIP"), to be published in June 2016 and November 2016, respectively, will integrate the community health care priorities and strategies identified in SMHS's current CHNA. Ex. A, pp. 80-81; Ex. L, pp. 1031-1032.

28. The CHNA, developed by SMHS in conjunction with the Greater Waterbury Health Improvement Partnership, identified access to care, availability of mental health and substance abuse services, obesity and tobacco use as priority areas of improvement for the Waterbury area. Greater Waterbury Health Improvement Partnership, *Community Health Needs Assessment Final Summary Report* 45 (Sept. 2013). Ex. A, p. 233.

29. To address chronic health conditions, THC will use community outreach to implement its Community Health and Well-Being Strategy, which emphasizes reducing the number of uninsured, recruiting multi-cultural and multi-lingual input from the community, prioritizing obesity prevention and tobacco control and transforming safety net care. The Hospital's current strategic focus area, in an effort to align its focus with that of the Connecticut Hospital Association, also addresses asthma in the community. Ex. L, p. 1030; Testimony of Mr. Connolly, Ex. N, pp. 23-25.

30. The SIP will follow the recommendations of the CHNA. Testimony of Mr. Connolly, Ex. N, p. 25.

31. The Hospital will be supported with resources in the form of regional and national experts to participate in national initiatives from the corporate headquarters of THC. Testimony of Mr. Dadlez, Ex. N, pp. 25-26.

32. SMHS currently leases space to Connecticut Children's Medical Center to provide inpatient services and the Hospital will continue to so following implementation of the proposal. Ex. A, pp. 39-40.

33. Following implementation of the proposal, TH-NE and Waterbury Hospital will work collaboratively to ensure the continued coordination of services provided by the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury. Ex. E, p. 865.

34. Existing referrals patterns will remain unchanged. Ex. A, p. 57.

35. The Hospital will continue to operate for the benefit of the community and serve the poor and underserved, including supporting wellness, health education and other community programs, participating in medical research and governmental health care programs and identifying gaps in services in the community. Ex. A, p. 114.

36. The transfer of ownership will be complete by 10/1/2016. Ex. A, p. 70.

37. Overall volume for the Hospital fluctuated slightly from FY2012 through FY2015. Inpatient volume is projected to decrease .5% each year from FY2017 through FY2019 due to an expected continued shift of services performed as outpatient procedures.

**TABLE 2**
**SAINT MARY'S HOSPITAL HISTORICAL DISCHARGES**

| Service | Actual Volume (Last 3 Completed FYs) | | | |
|---|---|---|---|---|
| | FY 2012 | FY 2013 | FY 2014 | FY 2015 |
| Medical/Surgical (Adult) | 9,129 | 8,826 | 8,842 | 9,062 |
| Maternity | 1,021 | 977 | 1,066 | 1,070 |
| Psychiatric | 625 | 669 | 633 | 654 |
| Rehabilitation | 0 | 0 | 0 | 0 |
| Pediatric | 0 | 0 | 0 | 0 |
| Neonatal ICU | 439 | 414 | 146 | 146 |
| Newborn | 864 | 843 | 955 | 913 |
| **Total** | **12,078** | **11,729** | **11,642** | **11,845** |

**TABLE 3**
**SAINT MARY'S HOSPITAL HISTORICAL PATIENT DAYS**

| Service | Actual Volume (Last 3 Completed FYs) | | | |
|---|---|---|---|---|
| | FY 2012 | FY 2013 | FY 2014 | FY 2015 |
| Medical/Surgical (Adult) | 41,395 | 41,900 | 40,663 | 40,360 |
| Maternity | 2,775 | 2,609 | 2,855 | 2,775 |
| Psychiatric | 3,994 | 4,099 | 3,933 | 4,139 |
| Rehabilitation | 0 | 0 | 0 | 0 |
| Pediatric | 0 | 0 | 0 | 0 |
| Neonatal ICU | 1,390 | 1,303 | 1,240 | 1,227 |
| Newborn | 2,022 | 1,922 | 2,173 | 2,055 |
| **Total** | **51,576** | **51,833** | **50,924** | **50,556** |

**TABLE 4**
**SAINT MARY'S HOSPITAL CURRENT & PROJECTED DISCHARGES BY SERVICE**

| Service | Projected Volume | | | |
|---|---|---|---|---|
| | FY 2016 | FY 2017 | FY 2018 | FY 2019 |
| Medical/Surgical (Adult) | 9,114 | 9,055 | 8,996 | 8,937 |
| Maternity | 1,119 | 1,119 | 1,119 | 1,119 |
| Psychiatric | 600 | 600 | 600 | 600 |
| Rehabilitation | 0 | 0 | 0 | 0 |
| Pediatric | 0 | 0 | 0 | 0 |
| Neonatal ICU | 146 | 146 | 146 | 146 |
| Newborn | 896 | 896 | 896 | 896 |
| **Total** | **11,875** | **11,816** | **11,757** | **11,698** |

**TABLE 5**
**SAINT MARY'S HOSPITAL CURRENT & PROJECTED PATIENT DAYS BY SERVICE**

| Service | Projected Volume | | | |
|---|---|---|---|---|
| | FY 2016 | FY 2017 | FY 2018 | FY 2018 |
| Medical/Surgical (Adult) | 40,900 | 40,645 | 40,392 | 40,140 |
| Maternity | 2,914 | 2,914 | 2,914 | 2,914 |
| Psychiatric | 3,769 | 3,769 | 3,769 | 3,769 |
| Rehabilitation | 0 | 0 | 0 | 0 |
| Pediatric | 0 | 0 | 0 | 0 |
| Neonatal ICU | 1,220 | 1,220 | 1,220 | 1,220 |
| Newborn | 2,228 | 2,228 | 2,228 | 2,228 |
| **Total** | **51,031** | **50,776** | **50,523** | **50,271** |

Ex. A, pp. 71-75.

38. Medicaid is the primary payer for nearly a third of the patients served by the Hospital. The Applicants do not anticipate any significant changes in payer mix as a result of this proposal.

**TABLE 6**
**SAINT MARY'S HOSPITAL CURRENT & PROJECTED PAYER MIX[1]**

| Payer | Most Recently Completed FY2015 | | Projected | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | FY2016 | | FY2017 | | FY2018 | | FY2019 | |
| | Discharges[2] | % | Discharges[2] | % | Discharges[2] | % | Discharges[2] | % | Discharges[2] | % |
| Medicare* | 5,289 | 45% | 5,313 | 45% | 5,276 | 45% | 5,240 | 45% | 5,214 | 45% |
| Medicaid* | 3,703 | 31% | 3,696 | 31% | 3,683 | 31% | 3,671 | 31% | 3,653 | 31% |
| CHAMPUS & TriCare | 22 | 0% | 22 | 0% | 22 | 0% | 22 | 0% | 22 | 0% |
| **Total Government** | **9,014** | **76%** | **9,031** | **76%** | **8,981** | **76%** | **8,933** | **76%** | **8,888** | **76%** |
| Commercial Insurers* | 2,601 | 22% | 2,613 | 22% | 2,604 | 22% | 2,594 | 22% | 2,581 | 22% |
| Uninsured | 103 | 1% | 102 | 1% | 102 | 1% | 101 | 1% | 100 | 1% |
| Workers Compensation | 129 | 1% | 129 | 1% | 129 | 1% | 129 | 1% | 128 | 1% |
| **Total Non-Government** | **2,833** | **24%** | **2,844** | **24%** | **2,835** | **24%** | **2,824** | **24%** | **2,810** | **24%** |
| **Total Payer Mix** | **11,847** | **100%** | **11,875** | **100%** | **11,816** | **100%** | **11,757** | **100%** | **11,698** | **100%** |

*Includes managed care activity
[1] Fiscal year is October through September
[2] Volume equals equivalent discharges
Ex. A, p 63.

39. There will be no changes in services for indigent or Medicaid recipients. Ex. A, p. 48.

40. The Hospital's policies, procedures and guidelines on charity care and financial assistance policies will be reviewed to ensure compliance with the new Internal Revenue Code Section 501(r) requirements effective January 1, 2016. Ex. A, p. 82; Ex. E, p. 870.

41. The Hospital's charitable policies are consistent with those of both THC and TH-NE Ex. E, p. 870; Testimony of Mr. Hartley, Ex. N, p. 31.

42. Saint Mary's Hospital Foundation, Inc. will continue to be a separate endowed foundation supporting the Hospital and the Hospital's subsidiaries. The Hospital will continue to comply with existing donor restrictions of the Foundation. Ex. A, p. 17; 114.

43. The Hospital will retain all assets and property currently belonging to SMHS. Ex. A, p. 21.

44. There are no planned changes to existing reimbursement contracts or billing practices between the Applicants and payers as a result of this proposal. Ex. A, p. 83; Ex. E, p. 865.

45. The Hospital will have access to TH-NE's internal Value Analysis Committee and its group purchasing agreements providing advantageous pricing for products and supplies. Ex. A, p. 53, 85.

46. The most recent credit ratings for THC are as follows:
    - Fitch (December 2015): AA/Negative Outlook;
    - S&P (December 2015): AA-/Stable Outlook; and
    - Moody's (December 2015): Aa3/Stable Outlook.

    Ex. E, p. 871.

47. THC and TH-NE have agreed to ensure the expenditure of $100 million for capital expenditures at the Hospital and its current subsidiaries over the next five years following the closing date. If specific performance metrics are met in the 3rd and 4th year following the close of the transaction, an additional $10 million of committed capital in both the 4th and 5th fiscal year will be available. Ex. A, p. 21; Ex. E, p. 866.

48. The $100 million capital commitment, and additional $20 million if certain metrics are met, will be part of the $275 million capital commitment THC made to the recently formed TH-NE. THC is responsible for the $275 million capital commitment to TH-NE with TH-NE being responsible to ensure $120 million of the capital is allocated to the Hospital and its current subsidiaries. Ex. E, p. 866; Ex. G, p. 1018.

49. The funding sources of THC's $100M capital commitment will be:
    - Available cash and investments generated by the hospital;
    - Financing obtained through the THC system debt program; and
    - Capital contributions from THC, to the extent necessary.

    Ex. A, p. 116; Ex. E, p. 866.

50. The Hospital's annually budgeted $12 million for routine capital purchases is included in the $100 million capital commitment from TH-NE. Ex. E, p. 869.

51. Operating revenue from one hospital could be used to help fund capital improvements at another hospital within TH-NE, if a hospital is unable to raise the needed capital through its own operations. Testimony of Mr. Bittner, Ex. N, pp. 59-60.

52. The commitment of $100 million for the Hospital and its subsidiaries will not be reduced if future acquisitions were to take place. Ex. G, p. 1017.

53. The table below provides a preliminary capital investment plan for the Hospital. Approximately $40 million is for routine capital needs while the remaining $60 million is for strategic investments.

**TABLE 7**
**PRELIMINARY CAPITAL INVESTMENT PLAN FOR THE HOSPITAL (IN THOUSANDS)**

| Description | Five Year Total |
|---|---|
| Hospital facility upgrades | $ 22,000 |
| Replacement of clinical equipment | $18,000 |
| Information Technology & Electronic Health Records | $12,000 |
| Urgent Care / Ambulatory Care | $10,000 |
| Ambulatory pavilion on campus | $25,000 |
| Conversion to private patient rooms | $8,000 |
| Clinically integrated network development | $5,000 |
| **Total estimated capital expenditures** | **$100,000** |

Ex. A, p.82.

54. The Hospital will have access to THC's intercompany loan program, if necessary, to develop a health information technology exchange (HITE) and electronic health records system. Ex. A, p. 31.

55. The Hospital will be subject to an annual intercompany system fee by TH-NE one year from the close of the transaction to help cover shared system office services. The shared resources include the departments of revenue, treasury, human resources, supply chain management and information technology. This will reduce the need for members of the TH-NE to use outsourced accounting, legal and consulting firms. Ex. E, p. 873-874; Ex. G, p. 1016-1017.

56. The shared system office services and resources-- and concomitant fee-- may increase to include additional resources and services in the future. Testimony of Mr. Bittner, Ex. N, pp. 49-50.

57. THC charges TH-NE 0.8% of operating expenses for providing the shared system office services. TH-NE will allocate the charge among its member hospitals and other subsidiaries. The fee will be determined based on the members 'comparative use of the system resources. Ex. G, p. 1016; Ex. L, pp. 1032-1033.

58. Based on savings observed at hospitals previously acquired by THC, an annual savings of at least 1% of the Hospital's operating revenue ($3.1M) is anticipated as a result of this proposal. Ex. A, p. 432.

59. The Hospital projects no incremental revenue for the first three fiscal years (FY 2016-2018) following the change in ownership, however operating gains of $1.5M, $3.1M and $3.2M, respectively, will be achieved from reductions in the cost of supplies and drugs and other operating expenses. Overall and with CON approval, the Hospital projects positive increasing gains from operations over the same time period.

**TABLE 8**
**SAINT MARY'S HOSPITAL PROJECTED INCREMENTAL REVENUES AND EXPENSES (in thousands)**

| | FY 2016 | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|---|
| Revenue from Operations | $0 | $0 | $0 | $0 |
| Total Operating Expenses | $0 | ($1,538) | ($3,133) | ($3,241) |
| **Gain/Loss from Operations** | **$0** | **$1,538** | **$3,133** | **$3,241** |

**TABLE 9**
**SAINT MARY'S HOSPITAL PROJECTED REVENUES AND EXPENSES WITH CON (in thousands)**

| | FY 2016 | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|---|
| Total Operating Revenue | $301,416 | $310,435 | $319,530 | $328,683 |
| Total Operating Expenses | $297,061 | $303,963 | $311,078 | $319,960 |
| **Gain/Loss from Operations** | **$4,355** | **$6,472** | **$8,453** | **$8,723** |

Ex. A, pp. 432-434; Testimony of Mr. Wable, Ex. N, p. 38.

60. The projected operational cost savings are summarized by expense category in the table below:

**TABLE 10**
**SAINT MARY'S HOSPITAL PROJECTED OPERATING EXPENSE SAVINGS WITH CON (in thousands)**

| Expense Category | FY 2016 | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|---|
| Supplies and Drugs | $0 | ($720) | ($1,512) | ($1,588) |
| Other Operating Expenses | 0 | ($817) | ($1,621) | ($1,654) |
| **Total Reductions** | **$0** | **($1,538)** | **($3,133)** | **($3,241)** |

Ex. A, p. 434;

61. THC's acquisitions of health systems and hospitals have yielded improved financial performances, cost savings and new capital investments:
    - Chelsea Community Hospital, Michigan - nearly a 40% increase in revenue between FY 2011 and FY 2016; approximately $67 million capital investment to construct a tower, including conversion to private acute beds; operating margin improved from 0.6% pre-merger to 4.4% in FY 2016;
    - Mercy Health, Hackley Campus, Michigan - annual aggregate savings of $1 million from enhanced revenue management and reduced supply and vendor costs; awarded 2016 America's Best Hospitals by Healthgrades; operating margin of 10% in FY 2015 compared to 1.0% in FY 2009, the first year after merging with THC;
    - St. Alphonsus Regional Medical Center, Idaho - $225 million in investments planned for campus relocation that would capture a broader patient base (easier patient access) and enhance physician recruitment and satisfaction; increase in Operating Cash Flow Margin to 16.3%, up from 6.4% in FY 2011; operating margin currently at 9.8%;
    - Loyola University Health System, Illinois - improved its first-year operational performance by $44.5 million across support functions, including insurance/risk

management, organizational integrity, supply chain, treasury, information services and revenue cycle; operating margin and operating cash flow margins have improved from -1.4% and 4.0% respectively to 1.2% and 6.5% in FY 2015;

- Catholic Health East, with facilities across 9 states - $285 million of synergies since the system level mergers occurred in May 2013, with more than $25 million in additional synergies planned through June 2016; operating expenses of $13.9 billion in FY 2015 with synergies savings of 1.8% of operating expenses; and
- St. Joseph Health, Inc., New York - $4 million in savings since merging with THC on July 2015 representing a synergies savings of 0.6% of operating expenses.
- St. Francis Hospital and Medical Center, Connecticut - has been a part of THC for over a quarter, but anticipated annualized savings of 7.6 million is expected to be realized representing 1% of operating expenses; a fixed pay interest rate swap was transferred to THC resulting in $44 million reduction in liability strengthening the balance sheet by increasing its unrestricted net assets.

Ex. E, pp. 872-873; Ex. G, p. 1018-1021.

62. There have been no changes in the price structure resulting from recent acquisitions other than St. Alphonsus Medical Center. Prices increased by approximately 12% as prior to the acquisition, prices had not increased for four years. Ex. G, p. 1021.

63. The Membership Transfer Agreement provides that within one year following closing, THC will develop a plan to address the Hospital's third party debt and to fully fund its pension plan obligations. Ex. A, pp. 114-115.

64. The Hospital's pension plan is underfunded by $75.9 million and its funding status was at 48% as of 9/30/2015. Currently, there are no plans to restructure the debt. A review to determine if an intercompany loan will be used to pay off or refinance the outstanding debt will be conducted post-closing. Ex. E, pp. 870-871; Ex. L, p. 1025; Testimony of Mr. Bittner, Ex. N, pp. 55-56.

65. 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))

66. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

67. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

68. 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))

69. 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))

70. 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))

71. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

72. The Applicants provided historical utilization of Saint Mary's Health System services in the service area that supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

73. The Applicants have satisfactorily demonstrated that this proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

74. 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))

75. 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))

76. 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 considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

Saint Mary's Health System, Inc. ("SMHS") is a not-for-profit integrated Catholic health care delivery system serving the greater Waterbury area. *FF1.* SMHS is the parent company of Saint Mary's Hospital, Inc. ("Hospital"), and various other subsidiaries and affiliates. *FF2.* The Hospital, a 347-bed acute care general hospital, has served the greater Waterbury area since 1907, and is licensed as a Level II Trauma Center. It provides a full range of inpatient, outpatient and ancillary services to the 16 towns encompassing its primary service area. *FF3-4.*

In response to changes in health care delivery as well as federal health policy and reimbursement reform, SMHS's 2016-2020 Strategic Plan emphasized a shift from a fee-for-service structure to that of an accountable care organization focusing on population health management. SMHS determined it could best effectuate this and other goals of its strategic plan through a partnership. *FF5.* Additionally, the need for capital improvements to an aging infrastructure, the mandate to provide health services as reflected in the Community Health Needs Assessment, the requirement to meet the medicals records standard as a result of the Patient Protection and Affordable Care Act ("PPACA") and SMHS's debt obligations have made the need to partner with another health care provider essential in order to maintain the quality of care currently provided. *FF6.* SMHS, through its SMHS Board Taskforce ("Taskforce"), has been searching for a partner that would meet its philosophical principles and the resources to improve SMHS's financial strength. *FF7.* The Taskforce found Trinity Health Corporation ("THC") and the New England Regional Health Ministry ("TH-NE") to have a strategic plan similar to its own while sharing a common vision, philosophy, mission and compatible religious directives. *FF7-8.*

THC is a national Catholic health care system with 88 hospitals, 126 continuing care facilities, home health and hospice programs in 21 states. It is the sole shareholder of TH-NE. *FF11.* TH-NE is the parent company of health care facilities located in Connecticut, including Saint Francis Hospital in Hartford. *FF12.*

SMHS's Board of Directors approved a strategic alliance with TH-NE based on the findings and recommendation of the Taskforce. A membership agreement was signed on September 19, 2015. *FF9.* As a result of this agreement, the Applicants are requesting approval to transfer ownership of SMHS and its subsidiaries to TH-NE in order to become part of THC. *FF10.*

Following the completion of the transfer of ownership, it is anticipated that SMHS will be dissolved, leaving the Hospital as the surviving entity. *FF17.* TH-NE will be the sole corporate member of the Hospital and the Hospital will be a direct subsidiary of TH-NE. *FF18.* The Applicants propose adding two members from the Hospital's community to the TH-NE Board of Directors who will be appointed by THC for three years. *FF19.* The governing board of the Hospital will remain unchanged other than the addition of the CEO of TH-NE. *FF19.* To ensure

quality concerns and the local health needs of the community are identified, local boards will have the ability to pass on relevant information to the regional governing boards through a representative. *FF20.*

TH-NE's organizational structure aims to create a system that meets the PPACA's objectives of improving population health and enhancing patient care experience while controlling costs. *FF13.* The Hospital will be able to leverage TH-NE's data and evidence-based national infrastructure to align and support clinicians in a Unified Clinician Organization ("UCO"). This will enable medical practitioners to work collaboratively throughout the THC-system to advance patient safety, best practices, quality and patient satisfaction. Hospitals participating in the TH-NE's UCO initiative have seen a decrease in sepsis mortality and pressure ulcer rates as well as an increase in patient satisfaction measures. *FF15.* Additionally, to address the increasing cost of hospital readmission, THC has developed a post-acute affiliated network resulting in a more accurate and efficient transition of patients from the hospital to the next level of care. *FF16.* The Hospital will be able to take advantage of THC's UCO and the associated best practices.

The Health Resources and Services Administration has designated Central Waterbury as a as a medically underserved area and medically underserved population. By affiliating with THC, the Hospital will gain the resources to strengthen health care in the region. *FF 25-26.* The Hospital's 2013 Community Health Needs Assessment ("CHNA") has identified access to care, availability of mental health and substance abuse services, obesity and tobacco use as priority areas of improvement. *FF28.* The Hospital has also adopted the Connecticut Hospital Association's initiative to reduce instances of chronic conditions, specifically choosing to focus on asthma prevention. *FF29.* TH-NE has committed to integrating the health priorities identified by SMHS and the Hospital into its Community Health and Well-Being Strategy. *FF27.* The proposal will also benefit the local community by increasing access to resources of a large system, and its ability to develop more preventive and primary care services.

Following implementation of the proposal, an efficiency analysis will be conducted to assess whether the Hospital's current clinical practices are consistent with those of THC's in an effort to standardize processes. However, neither the Hospital's clinical services nor its locations are expected to change as a result of this proposal. *FF21.* Additionally, the Hospital's Board would be required to approve a termination or a reduction of a service if it were to occur within three years following implementation. *FF22.* There are no proposed changes in services for the indigent or the Medicaid patients served by the Hospital. Furthermore, The Applicants do not anticipate any significant changes in the overall payer mix. *FF38-39.*

SMHS's charitable policies are consistent with both THC and TH-NE with no planned changes, thus ensuring that access to services for the Medicaid and indigent population continue. *FF41.* All charitable gifts to the Hospital will remain a part of the Hospital's Foundation and will continue to operate separately from the Hospital. All donations will continue to comply with existing donor restrictions. *FF42-43.* As a result, the integration of the Hospital with THC and TH-NE will allow the Hospital to maintain its commitment to the poor, the uninsured and underinsured as well as the Medicaid population.

There are no capital cost associated with the Transfer Agreement between the Applicants. *FF23.* Additionally, the proposal will enable the Hospital to make needed capital upgrades and investments. As a condition of THC's 2015 acquisition of Saint Francis *Care* and subsequent establishment of TH-NE, THC made a capital commitment of $275M to TH-NE. *FF48.* TH-NE is now proposing to commit at least $100M of that capital funding over the next five years to the Hospital. NE-RHM will contribute an additional $20M if the Hospital meets specific metrics in the 3rd and 4th year following the close of the transaction. *FF47.* Funding for the committed capital will be derived from cash and investments generated by the Hospital, financing obtained through the THC-system debt program and, if necessary, capital contributions from THC. *FF49.* The committed capital of $100M is a minimum that will not erode if further mergers were to occur. *FF52.*

The preliminary capital investment plan includes $40M in Hospital facility upgrades including the replacement of clinical equipment that has been delayed due to budgetary constraints. The remaining $60M is intended for the development of an electronic health records system, improving ambulatory care, converting to private patient rooms and developing a clinical network. *FF53.* In addition, the Hospital will be able to secure better long-term capital at favorable interest rates utilizing THC's strong credit ratings as well as develop a plan to adequately fund its pension obligations. *FF25, FF63.*

Cost savings will be achieved at the Hospital as a result of synergies expected to be realized as a result of becoming part of a larger system. Some synergies will be realized through a system of shared office services by THC members. The departments of revenue, treasury, human resources, supply chain management and information technology will be centralized. *FF55.* For use of these services, THC will impose a charge of 0.8% of NE-RHM's operating expenses, to be distributed among NE-RHM's member hospitals. Centralizing these departments will, however, likely result in net savings for TH-NE's members. *FF57.*

Based on observations at hospitals previously acquired by THC, an annual savings of at least 1% of the Hospital's operating revenue is anticipated as a result of this proposal. *FF58.* No incremental revenue for FY 2016 to 2018 is projected; however, operating gains of $1.5M, $3.1M, and $3.2M, respectively, are projected, in part, from reductions in the cost of supplies and drugs. In addition, the Hospital projects positive and increasing gains from operations following the transfer. *FF59.*

As a result of the potential for improved financial performance and new capital investments, the Applicants have demonstrated that the proposal is financially feasible and that the financial strength of the health care system will be improved by providing the Hospital with financial stability through improved access to capital and debt financing to preserve and enhance existing services.

The proposal will allow the Hospital to access TH-NE's system of best clinical practices, centralized office functions, and cost savings measures. Such benefits will enable the Hospital to invest in beneficial capital upgrades while still meeting its debt obligations and maintaining positive financial margins.

As a result of these combined factors, the Applicants have satisfactorily demonstrated that there is a clear public need for the proposal and that quality of care will improve through integration with a national system providing a variety of clinical and financial benefits. Thus, the Applicant has demonstrated that the proposal is consistent with the Statewide Health Care Facilities and Services Plan.

# Order

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request for the transfer of ownership of SMHS and its controlled affiliates to Trinity Health – New England, Inc., a subsidiary of Trinity Health Corporation is hereby **Approved** under Conn. Gen. Stat. §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 THC remains the parent company and sole shareholder of the Trinity Health–New England, Inc. ("TH-NE") 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, and the right to impose and collect a civil penalty under Conn. Gen. Stat. § l9a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall submit schedules to OHCA setting forth Saint Mary's 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 applicable 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-613(b), 19a-639(a)(8) & (11); FF 21-22.*

2. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall identify and provide the Certificates of Incorporation for the THC or TH-NE -affiliated entities that shall directly own, operate and hold the Hospital's license post-closing. This entity shall be duly organized and validly existing under the laws of Connecticut and TH-NE 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-613(b), 19a-639(a)(8) & (11); FF 17-18*

3. TH-NE shall notify OHCA in writing of the Closing Date of the transfer of ownership 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 Transfer Agreement, including any and all schedules and exhibits; and
   b. Bylaws or similar governance documents for the Hospital.

   TH-NE may redact from the Transfer Agreement any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If TH-NE redacts 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-613(b); FF 9- 10, 19-20, 34.*

4. Following the completion of the Hospital's 2016 Community Health Needs Assessment (CHNA), TH-NE shall participate with the Hospital, and the key community stakeholders and health organizations, in conducting future CHNAs and shall provide a copy of the 2016 CHNA and its Implementation Strategy to OHCA within thirty (30) days of completion. TH-NE and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the new CHNA (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. In the event that the Hospital has already substantially completed its 2016 Implementation Strategy at the time of the signing of this Order, it may submit the information requested in the 6/18 initiative as an addendum within six months of the Closing Date. TH-NE shall publish the Community Health Needs Assessment and the Implementation Strategy on the website of the Hospital. Until such time as the CHNA and Implementation Strategy are submitted to OHCA, TH-NE shall continue to support and implement the Hospital's current CHNA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3) & (7); FF 27-30*

5. Within one hundred and eighty (180) days following the Closing Date, TH-NE shall submit a plan demonstrating how health care services will be provided by the Hospital for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and TH-NE. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 21-22, 24-25.*

6. Until such time as the Services Plan is submitted, TH-NE shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date.

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[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.

Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF -21-22*

7. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Condition 8 below until the capital commitment is satisfied TH-NE shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the Hospital and its affiliates from the minimum $100 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 funding source of the capital investment; indicate whether it was drawn from intercompany loans, operating revenue, capital contributions from THC or another source. If funding was drawn from another source, indicate the source.

    The reports shall be signed by the Hospital's or TH-NE'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-613(b), 19a-639(a)(3),(4) & (5); FF 47-49, 53*

8. For three (3) years following the Closing Date, TH-NE shall file the following information with OHCA on a semi-annual basis for the Hospital and TH-NE:

    a. The cost saving totals achieved in the following Operating Expense Categories for the Hospital and TH-NE 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 the Hospital and TH-NE. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/350 (statement of operations) or successor reports.

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-613(b), 19a-639(a)(4) & (5);* FF *47-49, 53*

9. For three (3) years following the Closing Date, TH-NE 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 the Hospital and TH-NE. 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. <u>Operating Performance</u>** |
| 1. Operating Margin |
| 2. Non-Operating Margin |
| 3. Total Margin |
| **B. <u>Liquidity</u>** |
| 1. Current Ratio |
| 2. Days Cash on Hand |
| 3. Days in Net Accounts Receivables |
| 4. Average Payment Period |
| **C. <u>Leverage and Capital Structure</u>** |
| 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. <u>Additional Statistics</u>** |
| 1. Income from Operations |
| 2. Revenue Over/(Under) Expense |
| 3. Cash from Operations |
| 4. Cash and Cash Equivalents |
| 5. Net Working Capital |
| 6. Free Cash Flow (and the elements used in the calculation) |
| 7. Unrestricted Net Assets/Retained Earnings |
| 8. Bad Debt as % of Gross Revenue |
| 9. Credit Ratings (S&P, FITCH or Moody's) |

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(4) & (5); FF 59-60*

10. TH-NE shall ensure that the Hospital maintains and adheres to the Hospital'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 the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the 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-613(b), 19a-639(a)(5),(6) & (11); FF 40-42*

11. For three (3) years following the Closing Date, TH-NE shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of the Hospital within 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 Hospital simultaneously with their 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-613(b), 19a-639(a)(5),(6) & (11); FF 40-42*

12. TH-NE shall maintain community benefit programs and community building activities for the 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 the Hospital's current programs, and TH-NE shall apply no less than a 1% increase per year for the next three (3) years toward the Hospital's community building activities in terms of dollars spent.

In determining the Hospital's participation and investment in both community benefits and community building activities, TH-NE shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

a. On an annual basis, TH-NE 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 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 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-613(b), 19a-639(a)(5),(6) & (11); FF 35.*

13. TH-NE shall work toward making culturally and linguistically appropriate services available and integrated throughout the Hospital's operations. Specifically, TH-NE shall ensure that the Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, TH-NE shall provide at the Hospital, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, TH-NE shall ensure that the Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, TH-NE shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the closing for three years and shall be posted on the 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 29.*

14. For three (3) years following the Closing Date, Trinity shall allow for one (1) community representative to serve as voting members of the Hospital's Board of Directors with rights and obligations consistent with other voting member under the Hospital's Board of Director Bylaws. The community representative shall be selected in consultation with the Mayor of Waterbury in order to ensure the appointment of one unbiased persons who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 19-20*

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

7-25-16
Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by D. SCOTT NORDLUND, EVP, GROWTH, STRATEGY + INNOVATION
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by _____, _____
(Print name) (Title)

July 22, 2016
Date

Duly Authorized Agent for
Trinity Health-New England

Signed by Christopher Dadlez, President + CEO
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/27/2016
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

7/22/16
Date

Duly Authorized Agent for
Saint Mary's Hospital

Signed by Chad W. Wable, FACHE, President and Chief Executive Officer
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health-New England

Signed by _____, _____
(Print name) (Title)

Date

Duly Authorized Agent for
Trinity Health Corporation

Signed by _____, _____
(Print name) (Title)

**OHCA HEARINGS - EXHIBIT AND LATE FILE FORM**

Applicants: Saint Mary's Health System, Inc. and Trinity Health, Inc.

DN: 15-32045-CON

Hearing Date: May 9, 2016

Time: 3:00 PM

Proposal: Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

| OHCA Exhibit # | Description |
|---|---|
| **1** | |
| **2** | |
| **3** | |
| **4** | |
| **5** | |

| Applicant Exhibit # | Description |
|---|---|
| 1 | Letter from Joan Hartley & Jeffery Berger |
| 2 | |
| 3 | |
| 4 | |
| 5 | |

| Intervenor Exhibit # | Description |
|---|---|
| **1** | |
| **2** | |
| **3** | |
| **4** | |
| **5** | |
| **6** | |
| **7** | |

| Informal Exhibit # | Description |
|---|---|
| **1** | |
| **2** | |
| **3** | |
| **4** | |
| **5** | |
| **6** | |
| **7** | |

| Applicant Late File # | Description | Due Date | Rec'd |
|---|---|---|---|
| | | | |
| 1 | Support Schedule showing how cash flow amounts were determined | | |
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| Intervenor Late File # | Description | Due Date | Rec'd |
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| **6** | | | |

Notes:

# PUBLIC HEARING
# APPLICANT
# SIGN UP SHEET

**May 9, 2016**
**3:00 p.m.**

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

| PRINT NAME | Phone | Fax | Representing Organization |
|---|---|---|---|
| CHRISTOPHER DADLEZ | 860-714-1915 | | TRINITY HEALTH - NE |
| JAMES Richard O'Connell | 719-332-0340 | | TRINITY Health |
| DAVID BITTNER | 860-714-1950 | | TRINITY HEALTH - NE |
| James Hawnis | 860-714-4396 | | Trinity Health - NE |
| Adam Silverman | 860-714-1960 | | ↓ |

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Phone | Fax | Representing Organization |
|---|---|---|---|
| MARCOS M. McKINNEY | 860 805-5971 | | Trinity Health NE |
| Jennifer J. Schneider | 860 714-5360 | | Saint Francis Hospital. medical Ctr |
| Thomas S. Marcian | 860-331-2660 | | Hinckley Allen/Trinity Health NE |
| Robert J. Anthony | 860-509-6517 | | Brown Rudnick/Saint Mary's |
| Michael G. Taber | 401-457-5238 | | Hinckley Allen/Trinity Health NE |
| RALPH BECKER | 203-709-5871 | | SAINT MARY'S |
| Chris Hayes | 203-709-6294 | | Saint Mary's |
| Steven Schneider | 203 709 3044 | | SAINT MARYS |
| Claudia Capone | 860.276.7875 | | Trinity Health - NE |
| Robert J Mazurka | 203-888-9181 | | St. Marys |

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Phone | Fax | Representing Organization |
|---|---|---|---|
| Chad Wolfe | 203 709-3368 | | Saint Mary's Hospital |
| Liz Rotavera | 860 714-5153 | | Saint Francis |
| Chris Hartley | 860 714-5573 | | Saint Francis |
| PAT GERNER | 860 794-1907 | | SAINT MARY'S |
| Joe Connolly | 203 709 6369 | | SAINT MARY'S |
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Applicant

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Representing Organization |
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Public Official

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Phone | Fax | Representing Organization |
|---|---|---|---|
| [illegible] | | | |
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# PUBLIC HEARING
# PUBLIC OFFICIAL
# SIGN UP SHEET

**May 9, 2016**
**3:00 p.m.**

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

| PRINT NAME | Phone | Fax | Representing Organization |
|---|---|---|---|
| Ronald Pugliese | 203 723.4411 | 203 729-4512 | Naugatuck Economic Development Corp |
| William Quinn, Waterbury Dir. of Health | 203-574-6780 | 203-597-3481 | City of Waterbury, Dept. of Health |
| Lynn Ward | 203-757-0701 | 203-756-3507 | Waterbury Regional Chamber |
| Neil O'Leary | | | Mayor of Wtby |
| | | | |

# PUBLIC HEARING
# GENERAL PUBLIC
# SIGN UP SHEET

**May 9, 2016**
**3:00 p.m.**

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

| PRINT NAME | Representing Organization |
|---|---|
| Nicholas J Coscia | Open Health Patient |
| Amit Mody MD | TMNE |
| Mary Ann Hanley | St. Francis |
| Kevin Sullivan | Johnson Memorial Hospital |
| William [illegible], [illegible] | [illegible] |

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Representing Organization |
|---|---|
| Stuart E. Rosenberg | Johnson Memorial Hospital |
| Joseph Carlson II | Public |
| Paul Kelly | Public |
| Kevin Reynolds | RSG |
| Hillary Glass | RSG |
| Phil Tartsinis | JMMC |
| Fiona Phelan | Saint Francis |
| Brenda Sisco | RSG |
| Harry Rosenthal | YNHHS |
| S. Doloreshann CSJ | SMH |

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Representing Organization |
| --- | --- |
| Patty Chant | Waterbury Hospital |
| Dick Pugh | ST Marys Hospital |
| Christopher Mason | Republican-American Newspaper |
| Nancy Rousseau | Trinity Health New England |
| CHRIS MILLER | SHARON HOSPITAL |
| Peter Cordeau | Sharon Hospital |
| Christian Bergeron | Sharon Hospital |
| Jennifer Clement | Saint Marys Hospital |
| | |
| | |

**PUBLIC HEARING**
**GENERAL PUBLIC**
**SIGN UP SHEET**
**May 9, 2016**
**3:00 p.m.**

Docket Numbers: 15-32045-CON
Saint Mary's Health System, Inc. and Trinity Health, Inc.
Transfer of Ownership of Saint Mary's Hospital System to Trinity Health, Inc.

| PRINT NAME | Representing Organization |
|---|---|
| Nicholas J Coscia | Open Health Patient |
| Amit Mody MD | THNG |
| Mary Ann Hanley | St. Francis |
| Kevin Sullivan | Johnson Memorial Hospital |
| William [illegible], [illegible] | [illegible] |

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Representing Organization |
|---|---|
| Stuart E. Rosenberg | Johnson Memorial Hospital |
| Joseph Carlson | Public |
| Paul Kelly | Public |
| Kevin Reynolds | RSG |
| Hillary Glass | RSG |
| Phil Tartsinis | JMMC |
| Fiona Phelan | Saint Francis |
| Brenda Sisco | RSG |
| Nancy Rosenthal | YNHHS |
| S. Doloreshann CSJ | SMH |

Saint Mary's Health System, Inc. and Trinity Health, Inc.

| PRINT NAME | Representing Organization |
|---|---|
| Patty Chant | Waterbury Hospital |
| Jim Pugh | ST Mary's Hospital |
| CHRISTINA MASSA | REPUBLICAN-AMERICAN NEWSPAPER |
| Nancy Rousseau | Trinity Health New England |
| CHRIS MILLER | SHARON HOSPITAL |
| Peter Cordeau | Sharon Hospital |
| Christian Bergeron | Sharon Hospital |
| Jennifer Clement | Saint Mary's Hospital |
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| | |

State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

May 9, 2016

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Martone:

I am pleased to offer this testimony in support of the Certificate of Need application submitted by Trinity Health New England, Inc.'s Acquisition of Saint Mary's Health System, Inc. and Franklin Medical Group, P.C.

I am supportive of this merger, in part, because I believe that Saint Mary's will be able to retain their local commitment, including their Catholic identity and mission, while being part of a more financially secure regional system. The $100 million commitment over five years will allow Saint Mary's to improve the delivery of quality care and help fulfill its community based mission. Patients will have greater access to medical expertise and shared resources.

Changes are occurring in our health care delivery system. I view the change contemplated in this transaction as a very positive step for Saint Mary's and the Greater Waterbury community. I thank you for your consideration of this proposal.

Very Truly Yours,

Joan Hartley
State Senator, 15th District

Jeffrey J. Berger
State Representative, 73rd District

Printed on recycled paper.

## Greer, Leslie

**From:** Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
**Sent:** Friday, August 19, 2016 9:20 AM
**To:** Greer, Leslie
**Cc:** Attorney Bob Anthony; Lubin-Szafranski, Janeanne; Joe Connolly (JConnolly@Stmh.org); Victoria Cipriano
**Subject:** Responses to 15-32045-CON Conditions
**Attachments:** Responses to 15-32045-CON Conditions - CAC - 8 18 2016.pdf

Hello Leslie,

Attached are Saint Mary's responses to conditions for CON Docket #: 15-32045-CON. A paper copy is being mailed as well. Please feel free to contact me with any questions you may have.

Regards,

**Claudio A. Capone, FACHE**
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
Hartford, CT 06105
Office: 860-714-6165
Cell: 860-276-7975
Email: claudio.capone@trinityhealth-ne.org

Trinity Health
New England

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1000 Asylum Ave.
Hartford, CT 06106
860.714.6465
Fax: 860.714.8823

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

August 19, 2016

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capital Avenue
MS#13HCA
P.O Box 340308
Hartford, CT 06134-0308

RE: Docket Number: 15-32045-CON Transfer of ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England

Dear Mrs. Greer:

In accordance with Items 1, 2, 3, 6 & 10 of the Order dated July 27, 2016, enclosed is responses for each of the conditions noted above. Responses to the remaining conditions will be submitted prior to the requested deadline.

Please do not hesitate to contact me if you have any questions regarding this matter at 860-714-6165.

Thank you for your attention to this matter.

Sincerely,

Claudio A. Capone

Claudio A. Capone
Regional Vice President
Strategic Planning and Business Development

Enc.

1. **Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE shall submit schedules to OHCA setting forth Saint Mary's 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 applicable website of the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.**

   In accordance with Condition 1 of the Order, Trinity Health – New England, Inc. is submitting schedules to OCHA setting forth Saint Mary's Hospitals inpatient bed allocation along with the location & hours of operation for all outpatient services by department (**See Attachment 1**). Currently, locations and hours of operation can be viewed on the Saint Mary's Hospital's website (www.stmh.org).

2. **Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, TH-NE- affiliated entities that shall directly own, operate and hold the Hospital's license post-closing. The entity shall be duly organized and validly existing under the laws of Connecticut and TH-NE 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.**

   In accordance with Condition 2 of the Order, Trinity Health – New England, Inc. is submitting the Certificate of Incorporation for the TH-NE affiliated entities that shall directly own, operate and hold the hospital's license post-closing along with the document of existence under the laws of CT (**See Attachments 2**).

3. **TH-NE shall notify OHCA in writing of the Closing Date of the transfer of ownership 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 Transfer Agreement, including any and all schedules and exhibits; and**
   b. **Bylaws or similar governance documents for the Hospital.**

   **TH-NE may redact from the Transfer Agreement any information that is exempt from disclosure under Conn. Gen. Stat. 1-210. If TH-NE redacts materials in accordance with the previous sentence, the Applications 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.**

In accordance with Condition 3.a. of the Order, Trinity Health – New England, Inc. ("TH-NE") is submitting a copy of the Transfer Agreement, including any and all schedules and exhibits. Pursuant to Condition 3, TH-NE has redacted Schedule 6.15(a) from the copy of the Transfer Agreement submitted: Schedule 6.15(a) identifies correspondence from various state and federal agencies, contractors, and payors discussing matters relating to compliance with state and federal laws and reimbursement rules. The redacted information is exempt from disclosure because it is commercial or financial information given in confidence by the parties to each other even though such disclosure is not required by statute (see Conn. Gen. Stat. § 1-210 (5) (B)). Moreover, public disclosure of this information would unduly harm the parties and may create unwarranted unease among patients, potential patients, physicians, and other members of the community (**See Attachment 3**).

**6. Until such time as the Services Plan is submitted, TH-NE shall provide OCHA with notice of any reallocation of inpatient beds and relocation of outpatient services for the Hospital specific to those services that existed at the Hospital as of the Decision Date. Such notice shall be provided within ten (10) of any such reallocation or relocation and published on the website pages of Saint Mary's Hospital. OHCA is imposing this Condition to ensure continued access to health care services for patient population.**

In accordance with Condition 6 of the Order, Trinity Health – New England, Inc. ("TH-NE") is notifying OCHA that there are no plans to reallocate inpatient beds or relocate any outpatient services for Saint Mary's Hospital at this time.

**10. TH-NE shall ensure that the Hospital maintains and adheres to the Hospital'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 the Hospital's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the 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.**

In accordance with Condition 10 of the Order, Trinity Health – New England, Inc. will ensure that Saint Mary's will maintain and adhere to all of their current policies regarding charity care, indigent care and community volunteer services. Currently, all policies are located on the Saint Mary's Hospital website (www.stmh.org).

# ATTACHMENT 1

| IP Bed Allocation | |
|---|---|
| Department | Staffed Beds |
| Medical Acute (SH5) | 21 |
| Behavioral Health Services (OB1) | 12 |
| Telemetry | 20 |
| Orthopedics/Neuro (OB-4) | 30 |
| Medical Oncology (X-3) | 26 |
| General Surgery (OB-7) | 23 |
| Critical Care Unit | 16 |
| Cardiovascular Unit | 8 |
| Lobor/Delivery | 23 |
| Total Staffed Beds | 179 |

| OP Services by Department | | | |
|---|---|---|---|
| **Department** | **Location** | **Hours of Operation** | **Contact** |
| Behavioral Health Care Services | 100 Visitation Plaza Waterbury, CT 06706 | M, W & Th: 8A-8P T & F: 8A-4:30P | 203-709-6201 |
| Child Development Center | 100 Visitation Plaza Waterbury, CT 06706 | M-F: 6:30A - 5:45P | 203-709-6385 |
| Family Health Center | 95 Scovill Street Waterbury, CT 06706 | M-F: 8A - 4:30P | 203-709-3800 |
| Naugatuck Valley Surgical Center | 160 Robbins Street Waterbury, CT 06708 | M-F: 6A -5P | 203-755-6663 |
| Cardiovascular Diagnostic Center | 1320 West Main Street Waterbury, CT 06708 | M-F: 6:30A - 3P | 203-709-4506 |
| Saint Mary's Blood Draw - East Main Street | 1981 East Main Street Waterbury, CT 06705 | M-Th: 7A-4:30P F: 7A-3P Sat: 7A -10:45A Hours for X-Ray M-Th: 8A-5P F: 8A-12P | 203-709-6052 |
| Saint Mary's Blood Draw- West Main Street | 1312 West Main Street Waterbury, CT | M-F: 8A-6P Sat: 8A-2P Sun: 9A-1P Hours for X-Ray M-F: 8A-6P Sat: 8A-2P Sun: 9A-1P | 203-709-4575 |
| Saint Mary's Blood Draw- Scovill Street | 133 Scovill Street Waterbury, CT 06706 | M-F: 8:30A - 5P | 203-709-3660 |
| Saint Mary's Blood Draw-Southbury | 303 Union Square, Southbury CT | M-F: 7A-4P Sat: 7A-11A | 203-267-5611 |
| Saint Mary's Blood Draw- Watertown | 70 Hemingway Park Road Watertown, CT | M-F: 7:30A-4P | 203-709-5931 |
| Saint Mary's Urgent Care Center - Naugatuck | 799 New Haven Road, Naugatuck CT | M-F: 7A-6P Sat: 8A-2P Sun: 9A-1P | 203-723-5636 |
| Saint Mary's Urgent Care Center - Wolcott | 503 Wolcott Road, Wolcott CT | M-F: 7A-6P Sat: 8A-2P Sun: 9A-1P | 203-879-7900 |

| | | | |
|---|---|---|---|
| One Stop Testing (SMH) | 56 Franklin Street Waterbury, CT 06706 | M-F: 6A - 6P | 203-709-6103 |
| Saint Mary's Hospital Oncology Center | 1075 Chase Parkway Waterbury, CT 06708 | M-F: 7A-5P | 203-591-3077 |
| SMH Physical & Occupational Therapy - Waterbury | 1981 East Main Street Waterbury, CT 06705 | OT Hours<br>M& W: 8:30A-7P<br>T&Th: 7:30A-3P<br>F: 8:30A - 2:30P<br>PT Hours<br>M-Th: 7A-7P<br>F: 7A-5:30P | 203-709-6232 |
| SMH Physical Therapy & Low Vision Center - Naugatuck | 799 New Haven Road, Naugatuck CT | M, T & F: 8A - 4:30P<br>W & Th: 7A - 5:30P | 203-720-1750 |
| Saint Mary's Hospital Sleep Disorders Center - Wolcott | 503 Wolcott Road, Wolcott CT | Friday: 9A - 12P<br>Sleep Lab<br>9A-6P<br>7:30P - 6A | 203-709-6243 |
| Wound Center | 56 Franklin Street Waterbury, CT 06706 | M-F: 8A - 4:30P | 203-709-3000 |
| Saint Mary's OP Therapy | 56 Franklin Street Waterbury, CT 06706 | M-F: 8A - 4:30P | 203-709-6216 |
| OP Cardiac Rehab | 56 Franklin Street Waterbury, CT 06706 | M-F: 7A - 3:30P | 203-709-6202 |
| Saint Mary's OP Imaging | 56 Franklin Street Waterbury, CT 06706 | M-F: 6:30A - 8P<br>Sat & Sun: 7A - 3:30P | 203-709-6021 |
| Same Day Surgery | 56 Franklin Street Waterbury, CT 06706 | M-F: 6A - 8P | 203-709-6069 |
| Nutrition Center | 56 Franklin Street Waterbury, CT 06706 | M: 11A - 5:30P<br>T-F: 8:30A - 3:30P | 203-709-3247 |
| Saint Mary's Occupational Health & Diagnostic Center | 1312 West Main Street Waterbury, CT | M-F: 8A - 4:30 P | 203-709-3740 |
| Saint Mary's Hospital Urgent Care - West Main Street | 1312 West Main Street Waterbury, CT | M-F: 8A - 8P<br>Sat: 9A - 5P<br>Sun: 9A - 2P | 203-709-4575 |
| OP Pulmonolgy Clinic | 56 Franklin Street Waterbury, CT 06706 | M-F: 8A - 4P | 203-709-6244 |
| OP Cardiac Testing | 56 Franklin Street Waterbury, CT 06706 | M-F: 7A - 3:30P | 203-709-6361 |

# ATTACHMENT 2

**AMENDED 11/17/2015**

**Amended and Restated Certificate of Incorporation of**

**Trinity Health – New England, Inc.**

A Connecticut Nonstock Corporation

1. This Amended and Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

2. The text of the Amended and Restated Certificate of Incorporation is as follows:

## ARTICLE I

### Name

The name of the Corporation is Trinity Health – New England, Inc. which was incorporated on July 31, 1997.

## ARTICLE II

### Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation as amended from time to time.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Trinity Health – New England, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Trinity Health Corporation, an Indiana nonprofit corporation, which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

## ARTICLE III
## Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which,

in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Member and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

B. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

C. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

D. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

E. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

F. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations

exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

G. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

H. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) (or, if the Corporation is so classified, Section 509(a)(1) or 509(a)(2) of the Code).

## ARTICLE IV

### Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

## ARTICLE V

### Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Trinity Health Corporation, an Indiana nonprofit corporation.

## ARTICLE VI

### Registered Office and Resident Agent

The address of the Corporation's registered office is c/o CT Corporation System, One Corporate Center, Hartford, CT 06103. The resident agent of the Corporation is CT Corporation System, One Corporate Center, Hartford, CT 06103. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

## ARTICLE VII

### Membership

Trinity Health Corporation, an Indiana nonprofit corporation is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member shall have exercised its reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member:

a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if any such action is recommended by the Board of Directors of the Corporation, approve such action as recommended;

(b) Appoint and remove Directors of the Corporation, with or without cause, of if any such action is recommended by the Board of Directors of the Corporation, approve such action as recommended;

(c) Ratify the appointment and removal of the Chair of the Board of Directors of the Corporation;

(d) Appoint and remove the President of the Corporation;

(e) Approve the strategic plan of the Corporation to the extent required pursuant to the System Authority Matrix, which shall be consistent with the strategic plan of Trinity Health;

(f) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health;

(g) Approve the operating and capital budgets of the Corporation;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries);

(j) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation;

(k) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation;

(l) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may be subject to approval by Catholic Health Ministries);

(m) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code;

(n) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by Trinity Health pursuant to this provision;

(o) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than to Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business; and

(p) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit corporations, as the case may be) by the state laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

## ARTICLE VIII

## Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a director, officer, employee, committee member, or agent of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

## ARTICLE IX

## Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for

such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

## ARTICLE X

### Effective Date of This Amended and Restated Certificate of Incorporation

This Amended and Restated Certificate of Incorporation is effective as of October 1, 2015.

Office of the Secretary of the State of Connecticut

I, the Connecticut Secretary of the State, and keeper of the seal thereof, DO HEREBY CERTIFY, that the certificate of incorporation of

TRINITY HEALTH - NEW ENGLAND, INC.

a domestic NONSTOCK corporation, was filed in this office on July 31, 1997, a certificate of dissolution has not been filed, the corporation has filed all annual reports, and so far as indicated by the records of this office such corporation is in existence.

Secretary of the State

Date Issued: August 10, 2016

Business ID: 0568101 Express Certificate Number: 2016249150001

Note: To verify this certificate, visit the web site http://www.concord.sots.ct.gov

# ATTACHMENT 3

Execution Copy

# TRANSFER AGREEMENT

**by and among**

**SAINT FRANCIS CARE, INC. and TRINITY HEALTH CORPORATION**

**and**

**SAINT MARY'S HEALTH SYSTEM, INC. and SAINT MARY'S HOSPITAL, INC.**

**Dated as of September 18, 2015**

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# TRANSFER AGREEMENT

This Transfer Agreement (this "**Agreement**"), dated as of September 18, 2015 (the "**Signature Date**"), is entered into by and among Saint Francis Care, Inc. ("**NE-RHM**"), a Connecticut non-stock corporation, Trinity Health Corporation, an Indiana nonprofit corporation ("**Trinity Health**"), and Saint Mary's Health System, Inc. ("**SMHS**") and Saint Mary's Hospital, Inc. ("**SMH**"), both Connecticut non-stock corporations (SMHS, SMH and their wholly owned or controlled subsidiaries, collectively, "**Saint Mary's**"). NE-RHM, Trinity Health and Saint Mary's are sometimes referred to herein individually as a "**Party**," and, collectively, as "**Parties**."

## RECITALS

1. Saint Mary's is an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community and includes SMH, a 347-bed general acute hospital, and related healthcare facilities.

2. NE-RHM is a regional Catholic health care provider in Connecticut, which has entered into a Membership Transfer Agreement with Trinity Health with the intent that NE-RHM will operate the Regional Health Ministry for most of Trinity Health's operations in Connecticut and Massachusetts (the "**Regional Health Ministry**") after the date that transaction is completed ("**Saint Francis/Trinity Transfer Date**"). References in this Agreement to NE-RHM before the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. as presently structured as a standalone regional provider. References to NE-RHM after the Saint Francis/Trinity Transfer Date refer to Saint Francis Care, Inc. restructured and renamed as the Trinity Health Regional Health Ministry for its operations in Massachusetts and Connecticut (the "**NE-RHM Service Area**").

3. Trinity Health is a multi-institutional Catholic healthcare system serving people and communities in 21 states, including Connecticut and Massachusetts.

4. Saint Mary's, NE-RHM and Trinity Health are each committed to the philosophy that healthcare services and programs should be offered in a quality setting with a commitment to the values of the Roman Catholic Church and that their facilities, services and programs, in the aggregate, should be operated on an efficient and financially sound basis so as to maintain their continued existence, viability and availability.

5. The Parties have determined that Saint Mary's would be an important part of Trinity Health's operations in the NE-RHM Service Area and as part of NE-RHM will help promote quality and cost effective health care services through a continuum of care to those served by NE-RHM.

6. The Parties believe that the contemplated transaction will bring together organizations with shared vision, values, philosophy and mission and strengthen the Catholic healthcare tradition in the NE-RHM Service Area.

7. In furtherance of their shared vision, values, mission and philosophy, the Parties wish to enter into a transaction whereby Saint Mary's will become part of the Regional Health Ministry.

8. To accomplish the affiliation, NE-RHM shall become the sole corporate member of SMHS and will serve as SMHS's parent. It is anticipated that SMHS will be dissolved, restructured or merged with and into SMH. NE-RHM will be the primary organization for future Trinity Health expansion in the NE-RHM Service Area.

9. Saint Mary's wishes to join the Regional Health Ministry, through which the Parties intend to:

a. improve the infrastructure and capabilities required to deliver value-based accountable care and improve population health in the NE-RHM Service Area;

b. enhance the quality of care provided in the NE-RHM Service Area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

c. reduce the costs of healthcare in the NE-RHM Service Area;

d. expand services in the NE-RHM Service Area through both strategic and organic growth, including pursuant to an ambulatory care strategy; and

e. support physician alignment capabilities and initiatives that foster physician engagement while maintaining an open medical staff.

**NOW, THEREFORE,** in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

## ARTICLE I
## DEFINITIONS

The following terms have the meanings specified or referred to in this **Article I**:

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. The term "control" (including the terms "controlled by" and "under common control with") means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. An "Affiliate" will not be considered to be an "ERISA Affiliate" unless it complies with the definition of an "ERISA Affiliate," as provided in **Section 6.22(c)** hereof.

"**Agreement**" has the meaning set forth in the preamble.

"**Amended and Restated Certificates of Incorporation of SMHS and SMH**" means the amended and restated certificates of incorporation contemplated by **Section 2.01**.

"**Amended and Restated Bylaws of SMH**" means the amended and restated bylaws contemplated by **Section 2.01**.

"**Applicable Exceptions**" means applicable bankruptcy, insolvency, reorganization, moratorium and similar Laws affecting creditors' rights generally, and subject, as to enforceability, to general principles of equity (regardless of whether enforcement is sought in a proceeding at law or in equity).

"**Balance Sheet**" has the meaning set forth in **Section 6.06**.

"**Balance Sheet Date**" has the meaning set forth in **Section 6.06**.

"**Capital Expenditures**" means, with respect to Saint Mary's and the Saint Mary's Controlled Subsidiaries, expenditures that are capitalized in accordance with GAAP, including, without limitation, the expenditures described in **Section 4.02**.

"**CERCLA**" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. §§ 9601 et seq.

**"Certification of AFTAP"** has the meaning set forth in **Section 6.22(c)**.

"**Church Plan**" has the meaning set forth in **Section 6.22(e).**

"**Closing**" has the meaning set forth in **Section 5.01**.

"**Closing Date**" has the meaning set forth in **Section 5.01**.

"**COBRA**" means the group health plan continuation coverage requirements of Part 6 of Subtitle B of Title I of ERISA and Section 4980B of the Code and of any similar state or local Law.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Committed Capital**" has the meaning set forth in **Section 4.01**.

"**Confidentiality Agreement**" means confidentiality agreement entered into by the Parties on March 12, 2015 and amended on July 22, 2015.

"**Confidential Information**" has the meaning set forth in **Section 8.11(a)**.

"**Contracts**" means all contracts, leases, deeds, mortgages, licenses, instruments, notes, commitments, undertakings, indentures, joint ventures and all other agreements, commitments and legally binding arrangements, whether written or oral.

"**CONs**" has the meaning set forth in **Section 8.04**.

"**Disclosing Party**" has the meaning set forth in **Section 8.11(a)**.

"**Disclosure Schedules**" means the Disclosure Schedules initially delivered by Saint Mary's, NE-RHM and Trinity Health concurrently with the execution and delivery of this Agreement and as updated through Closing Date.

"**Effective Date**" has the meaning set forth in **Section 5.01**.

"**Encumbrance**" means any lien, pledge, mortgage, deed of trust, security interest, charge, claim, easement, encroachment or other encumbrance.

"**Environmental Claim**" means any Governmental Order, action, suit, claim, investigation or other legal proceeding by any Person alleging liability of whatever kind or nature (including liability or responsibility for the costs of enforcement proceedings, investigations, cleanup, governmental response, removal or remediation, natural resources damages, property damages, personal injuries, medical monitoring, penalties, contribution, indemnification and injunctive relief) arising out of, based on or resulting from: (a) the presence, Release of, or exposure to, any Hazardous Materials; or (b) any actual or alleged non-compliance with any Environmental Law or term or condition of any Environmental Permit.

"**Environmental Law**" means any applicable Law, and any Governmental Order or binding agreement with any Governmental Authority: (a) relating to pollution (or the cleanup thereof) or the protection of natural resources, endangered or threatened species, human health, or the environment (including ambient air, soil, surface water or groundwater, or subsurface strata); or (b) concerning the presence of, exposure to, or the management, manufacture, use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, production, disposal or remediation of any Hazardous Materials. The term "**Environmental Law**" includes, without limitation, the following (including their implementing regulations and any state analogs): CERCLA; the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended by the Hazardous and Solid Waste Amendments of 1984, 42 U.S.C. §§ 6901 et seq.; the Federal Water Pollution Control Act of 1972, as amended by the Clean Water Act of 1977, 33 U.S.C. §§ 1251 et seq.; the Toxic Substances Control Act of 1976, as amended, 15 U.S.C. §§ 2601 et seq.; the Emergency Planning and Community Right-to-Know Act of 1986, 42 U.S.C. §§ 11001 et seq.; and the Clean Air Act of 1966, as amended by the Clean Air Act Amendments of 1990, 42 U.S.C. §§ 7401 et seq.

"**Environmental Notice**" means any written directive, notice of violation or infraction, or notice respecting any Environmental Claim relating to actual or alleged non-compliance with any Environmental Law or any term or condition of any Environmental Permit.

"**Environmental Permit**" means any Permit required under or issued, granted, given, authorized by or made pursuant to Environmental Law.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"**ERISA Affiliate**" has the meaning set forth in **Section 6.22(c)**.

"**Exempt Subsidiaries**" means those Saint Mary's Controlled Subsidiaries that are exempt from federal income taxation pursuant to Section 501(a) of the Code, as organizations described in Section 501(c)(3) of the Code, which are identified as such on **Exhibit A**.

"**Financial Statements**" has the meaning set forth in **Section 6.06**.

"**Foundation**" has the meaning set forth **in Section 3.09(b)**.

"**GAAP**" means United States generally accepted accounting principles in effect from time to time.

"**Government Programs**" has the meaning set forth in **Section 6.16(a)**.

"**Governmental Authority**" means any federal, state, local or foreign government or political subdivision thereof, or any agency or instrumentality of such government or political subdivision, or any self-regulated organization or other non-governmental regulatory authority or quasi-governmental authority (to the extent that the rules, regulations or orders of such organization or authority have the force of Law), or any arbitrator, court or tribunal of competent jurisdiction.

"**Governmental Order**" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"**Hazardous Materials**" means: (a) any material, substance, chemical, waste, product, derivative, compound, mixture, solid, liquid, mineral or gas, in each case, whether naturally occurring or man-made, that is hazardous, acutely hazardous, toxic, or words of similar import or regulatory effect under Environmental Laws; and (b) any petroleum or petroleum-derived products, radon, radioactive materials or wastes, asbestos in any form, lead or lead-containing materials, urea formaldehyde foam insulation and polychlorinated biphenyls.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), as amended from time to time.

"**HITECH**" means the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII § 1301 et seq. of the American Recovery and Reinvestment Act of 2009, as amended from time to time.

"**HSR Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended from time to time.

"**Interested Person**" has the meaning set forth in **Section 6.20(a)**.

"**IRS**" means the Internal Revenue Service.

"**Joint Ventures**" means Heart Center of Greater Waterbury, Inc. and Harold Leever Regional Cancer Center, Inc.

"**Knowledge**" or any other similar knowledge qualification with respect to Saint Mary's means (i) the actual knowledge of those persons listed in **Schedule 1A** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committees, compliance committees or finance committees of Saint Mary's or the Saint Mary's Controlled Subsidiaries. Knowledge or any other similar knowledge qualification with respect to NE-RHM means (i) the actual knowledge of those persons listed in **Schedule 1B** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of NE-RHM. Knowledge or any other similar knowledge qualification with respect to Trinity Health means (i) the actual knowledge of those persons listed in **Schedule 1C** of the Disclosure Schedules, which shall consist of their own recollections, information in their files, information in written or electronic communications to or from them and information attributable to them as a result of actions taken by them or (ii) information in the minutes of the boards of directors, executive committee, compliance committee or finance committee of Trinity Health.

"**Law**" means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree, other requirement or rule of law of any Governmental Authority.

"**Leased Real Property**" has the meaning set forth in **Section 6.12(b)**.

"**Material Adverse Effect**" means (a) as to NE-RHM, any event, occurrence, fact, condition or change that materially adversely impacts the ability of NE-RHM to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; (b) as to Trinity Health, any event, occurrence, fact, condition or change that materially adversely impacts the ability of Trinity Health to perform its obligations under this Agreement or to consummate the transactions contemplated by this Agreement; and (c) as to Saint Mary's, any event, occurrence, fact, condition or change that materially adversely impacts the business, results of operations, financial condition or assets of Saint Mary's, taken as a whole; provided, however, that as to Saint Mary's, "**Material Adverse Effect**" shall not include any event, occurrence, fact, condition or change, directly or indirectly, arising out of or attributable to: (i) general economic or political conditions in the United States or in the State of Connecticut; (ii) changes or conditions generally affecting the healthcare industry as a whole in the United States or in the State of Connecticut that are not unique to the operations of Saint Mary's, (iii) any action required or permitted by this Agreement or any action taken (or omitted to be taken) with the written consent of or at the written request of NE-RHM or Trinity Health, as the case may be; (iv) the acts or omissions of NE-RHM or Trinity Health, as the case may be, (v) any changes in applicable Laws or accounting rules (including GAAP) or the Ethical and Religious Directives described in **Section 3.06** below, or the enforcement, implementation or interpretation thereof; (vi) the announcement, pendency or completion of the transaction contemplated by this Agreement or any effect resulting from the announcement or pendency of the transaction contemplated by this Agreement; (viii) any natural or man-made disaster, acts of God, or acts of terrorism, sabotage, military action or war (whether or not declared) or any

escalation or worsening thereof; (ix) changes in the requirements, reimbursement rates, policies or procedures of third party payors, Governmental Authorities or accreditation commissions or organizations that are generally applicable to hospitals or healthcare facilities in the United States or the State of Connecticut; or (x) Saint Mary's failure to meet projections or revenue or earnings predictions for any period ending on or after the date hereof, provided, however, that this shall not prevent a determination that any change, event or effect underlying such a failure to meet projections or revenue or earnings predictions has resulted in a Material Adverse Effect (to the extent such a change, event or effect is not otherwise excluded from the definition of Material Adverse Effect).

"**Material Contracts**" has the meaning set forth in **Section 6.09(a)**.

"**Multiemployer Plan**" has the meaning set forth in **Section 6.22(d)**.

"**Multiple Employer Plan**" has the meaning set forth in **Section 6.22(d)**.

**"NE-RHM"** has the meaning set forth in the preamble.

**"NE-RHM Controlled Subsidiary"** means any Person that is controlled by NE-RHM. The term "control" is defined in the definition of "Saint Mary's Controlled Subsidiary", below.

**"NE-RHM Providers"** means Saint Francis Hospital and Medical Center, Mount Sinai Rehabilitation Hospital, Inc., Saint Francis Medical Group, Inc., Saint Francis Emergency Medical Group, Inc., Asylum Hill Family Medical Center, Inc., Collaborative Laboratory Services, LLC, MedWorks, LLC, Saint Francis Behavioral Group, P.C., and Saint Francis Care Medical Group, P.C.

"**NE-RHM Service Area**" has the meaning set forth in the preamble.

"**OHCA**" has the meaning set forth in **Section 8.04**.

"**Organizational Documents**" means (a) in the case of a Person that is a corporation, its articles or certificate of incorporation and its by-laws, regulations or similar governing instruments required by the laws of its jurisdiction of formation or organization; (b) in the case of a Person that is a partnership, its articles or certificate of partnership, formation or association, and its partnership agreement (in each case, limited, limited liability, general or otherwise); (c) in the case of a Person that is a limited liability company, its articles or certificate of formation or organization, and its limited liability company agreement or operating agreement; and (d) in the case of a Person that is none of a corporation, partnership (limited, limited liability, general or otherwise), limited liability company or natural person, its governing instruments as required or contemplated by the laws of its jurisdiction of organization.

"**Owned Real Property**" has the meaning set forth in **Section 6.12(a)**.

"**PBGC**" has the meaning set forth in **Section 6.22(a)**.

"**Plan**" has the meaning set forth in **Section 6.22(k)**.

"**Permits**" means all permits, licenses, franchises, approvals, authorizations and consents required to be obtained from Governmental Authorities.

"**Permitted Encumbrances**" has the meaning set forth in **Section 6.10(b)**.

"**Person**" means an individual, corporation, partnership, joint venture, limited liability company, Governmental Authority, unincorporated organization, trust, association or other entity.

"**Prohibited Transaction**" is defined in Sections 406 and 408 of ERISA and Section 4975 of the Code.

"**Potential Investment Opportunity**" has the meaning set forth in **Section 4.05**.

"**Real Property**" means, collectively, the Owned Real Property and the Leased Real Property.

"**Recipient**" has the meaning set forth in **Section 8.11(a)**.

"**Regional Health Ministry**" or "**RHM**" has the meaning set forth in the Recitals and in the Trinity Health Authority Matrix.

"**Release**" means any actual or threatened release, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, abandonment, or disposing into the environment (including, without limitation, ambient air, surface water, groundwater, land surface or subsurface strata).

"**Representative**" means, with respect to any Person, any and all directors, officers, employees, consultants, financial advisors, counsel, accountants and other agents of such Person.

"**Review Period**" has the meaning set forth in **Section 8.08(b)**.

"**Saint Francis/Trinity Transfer Date**" has the meaning set forth in the Recitals.

"**Saint Mary's**" has the meaning set forth in the preamble.

"**Saint Mary's Assets**" means all of the property and assets of Saint Mary's and each Saint Mary's Controlled Subsidiary of every kind, character or description, tangible or intangible, wherever located, and whether or not reflected on the Financial Statements.

"**Saint Mary's Benefit Plan**" has the meaning set forth in **Section 6.22(a)**.

"**Saint Mary's Controlled Subsidiary**" means any Person that is controlled by Saint Mary's. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the Controlled Subsidiary, whether through the ownership of voting securities, by contract or otherwise. The Controlled Subsidiaries are identified on **Exhibit B**.

"**Saint Mary's Employees**" has the meaning set forth in **Section 8.06(a)**.

"**Saint Mary's Leases**" has the meaning set forth in **Section 6.12(b)**.

"**Saint Mary's Providers**" means Saint Mary's Hospital, Inc., Saint Mary's Physician Partners, LLC, Diagnostic Imaging of Southbury, LLC, Naugatuck Valley MRI, LLC, and Franklin Medical Group, P.C.

"**Saint Mary's Retirement Plan**" means the Pension Plan for Employees of St. Mary's Corporation, as revised and restated effective October 1, 1997 (which corporate name was changed to Saint Mary's Hospital, Inc.), and as subsequently amended.

"**Signature Date**" has the meaning set forth in the preamble.

"**SMH**" or "**Saint Mary's Hospital**" means Saint Mary's Hospital, Inc.

"**Survey**" has the meaning set forth in **Section 8.08(b)**.

"**Taxes**" means all federal, state, local, foreign and other income, gross receipts, sales, use, production, ad valorem, transfer, franchise, registration, profits, license, lease, service, service use, withholding, payroll, employment, unemployment, estimated, excise, severance, environmental, stamp, occupation, premium, property (real or personal), real property gains, windfall profits, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest, additions or penalties with respect thereto and any interest in respect of such additions or penalties.

"**Tax Return**" means any return, declaration, report, claim for refund, information return or statement or other document required to be filed with respect to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

"**Title Commitment**" has the meaning set forth in **Section 8.08(a)**.

"**Title Company**" has the meaning set forth in **Section 8.08(a)**.

"**Title Policy**" has the meaning set forth in **Section 8.08(a)**.

"**Transaction Documents**" means this Agreement and the other agreements, instruments and documents required to be delivered at the Closing.

"**Trinity Health**" has the meaning set forth in the preamble.

**"Trinity Health Controlled Subsidiary"** means any Person that is controlled by Trinity Health. The term "control" is defined in the definition of "**Saint Mary's Controlled Subsidiary**," above.

"**Trinity Health System Authority Matrix**" means the description of governance and management responsibilities of Trinity Health and its subsidiaries, as such may be amended from time to time, the current copy of which is attached as **Exhibit C**, which describes the delegated authority from the Catholic Health Ministries and the Trinity Health Board of Directors to the governance and management of subsidiaries, including the RHM.

**"Withdrawal Liability"** has the meaning set forth in **Section 6.22(d).**

## ARTICLE II
## TRANSFER

**Section 2.01 Admission of NE-RHM as the Sole Member of SMHS; Restated Governance Documents of SMHS and SMH.** As of the Effective Date, and subject to the terms and conditions set forth in this Agreement, SMHS and SMH will be merged or other action will be taken so that NE-RHM shall be admitted as the sole corporate member of SMH; in the alternative, at Trinity Health's option, NE-RHM will be admitted as the sole corporate member of SMHS and as soon as reasonable after the Effective Date, SMHS and SMH will be merged or other action will be taken so that SMH is a direct subsidiary of NE-RHM. The Certificates of Incorporation and Bylaws of SMH (and, if applicable, SMHS) will be restated in the form attached as **Exhibit D.** The initial members of the SMH Board will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 2.01** to this Agreement. At Trinity Health's option, the Saint Mary's Controlled Subsidiaries will duly approve the adoption of amended and restated Organizational Documents, either as of or following the Effective Date, to reflect the admission of NE-RHM as the sole corporate member of SMH. As of the Effective Date, and except as mutually agreed to by the Parties in writing, and except as provided in the attached Disclosure Schedule with respect to the liability owed by SMH to Saint Mary's Retirement Plan all assets and properties of Saint Mary's shall remain as assets and properties of Saint Mary's and all outstanding liabilities of Saint Mary's shall remain as liabilities of Saint Mary's.

**Section 2.02 Church Plan Exemption Under the Code and Under ERISA; SMH or SMHS Bankruptcy.** In the event that the Church Plan Exemption from ERISA and the Code is determined for any reason to not be available to SMH by a court of competent authority, by settlement agreement of the parties, or by other legally enforceable means, or in the event that following the Effective Date, SMH, SMHS, or NE-RHM becomes subject to a voluntary federal bankruptcy proceeding involving SMH, SMHS, or NE-RHM as the debtor, then all financial and other legally enforceable obligations owed by SMH to the Saint Mary's Retirement Plan shall be assumed by Trinity Health. The parties recognize, acknowledge and agree that such assumption shall not require any payment or any other consideration to be provided by SMH to Trinity Health.

## ARTICLE III
## GOVERNANCE AND OPERATIONS OF THE NE- RHM; ADDITIONAL POST-EFFECTIVE DATE COVENANTS

**Section 3.01 Governance.** As of and following the Effective Date SMHS will be sponsored by Catholic Health Ministries, the public juridic person of pontifical right that sponsors Trinity Health, and will be guided by Trinity Health's mission and core values. Upon adoption of the Amended and Restated Certificate of Incorporation and Bylaws of SMHS, SMHS shall be part of NE-RHM's governance and management structure, consistent with the role of other components of NE-RHM.

**Section 3.02 NE-RHM Board of Directors**. As of the Effective Date, two members of the NE-RHM board will be appointed to the NE-RHM board by Trinity Health for a term of three years (the "Saint Mary's Members"). The Saint Mary's Members will be included on the NE-RHM board as community members. The Saint Mary's Members will be eligible for reappointment to the NE-RHM board in the same manner as other NE-RHM board members. The Saint Mary's Members will be identified by the Parties prior to the Closing Date and will be listed on **Schedule 3.02** to this Agreement.

**Section 3.03 Other Appointments.** A person designated by Saint Mary's will be appointed as one of the NE-RHM appointees to the TotalHealth, L.L.C ("TotalHealth") Board of Directors, consistent with the Organizational Documents of TotalHealth.

**Section 3.04 President and CEO of Saint Mary's**. Following the Effective Date, Chad W. Wable will continue to serve as the President and Chief Executive Officer of Saint Mary's, and will also have a substantial and meaningful regional oversight/governing role in the Regional Health Ministry (along with continued oversight of SMH). Mr. Wable's specific role with NE-RHM will be agreed to by the President and CEO of NE-RHM, Trinity and Mr. Wable and memorialized in an employment agreement prior to the Closing (the "Wable Employment Agreement").

**Section 3.05 Name and Branding.** Following the Effective Date, no changes to the names, trade names, and brands of the Saint Mary's Controlled Subsidiaries will take place without first consulting with the local boards, as applicable. Any future name, trade name, or branding changes for the Saint Mary's Controlled Subsidiaries will be determined and implemented in a manner that is consistent with Trinity Health branding policies that best preserve the current name, trade name and brand recognition while furthering the branding strategy of the Regional Health Ministry.

**Section 3.06 Catholic Identity.** Saint Mary's will continue its Catholic identity following the Effective Date and will be operated in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops. A chapel and all existing religious artifacts will be maintained at SMH.

**Section 3.07 Operational Commitments**. For a period of at least three (3) years following the Effective Date, SMH will not be closed, sold, transferred, "spun-off" or otherwise divested by NE-RHM ("SMH Divestiture"). During such three (3) year period, the SMHS board (or the board of the surviving corporation following consolidation of SMHS and SMH) must approve any termination or material reduction of an existing clinical service; however, the parties recognize that continuation of any clinical service shall take into account (i) evolving community needs, (ii) healthcare reform initiatives, opportunities and mandates, (iii) financial viability, and (iv) applicable Law. In addition, SMH will have access to the clinical resources and services, including physician professional services, of the Regional Health Ministry for medical and surgical specialties needed to meet the needs of the community served by SMH. Specifically, NE-RHM would, at a minimum, work with SMH to grow and develop the following services: cardiovascular services, including cardiothoracic surgery, interventional cardiology and other

aspects of cardiac diagnostic and therapeutic services; orthopedic services, including, but not limited to, major joint replacement services; and all aspects of oncology services.

**Section 3.08 Medical Staff.** Following the Effective Date, the medical staff, admitting privileges and medical staff bylaws of SMH will remain in place unless amended or changed in accordance with the medical staff bylaws of SMH.

**Section 3.09 Community Benefit.**

(a) Following the Effective Date, Saint Mary's will continue to operate for the benefit of the community and serve the poor and underserved. Trinity Health and NE-RHM intend to preserve Saint Mary's' longstanding and unwavering commitment to improving the health of those in the communities it serves. Additionally, and to the extent consistent with the changing needs of the communities served, the changing environment in which healthcare is provided, applicable Law, and Trinity Health and NE-RHM policies and practices, Saint Mary's will continue, either directly or through its subsidiaries: (i) offering medical education residency and fellowship programs, (ii) supporting wellness, health education and other community programs consistent with Saint Mary's' past policies and practices, (iii) participating in medical research programs and innovation activities, (iv) participating in governmental healthcare programs, (v) identifying community needs in the community and potential clinical improvements or enhancements, and (vi) supporting and enhancing education and community programs.

(b) Following the Effective Date, Saint Mary's Hospital Foundation, Inc. (the "**Foundation**") will continue to be a separately endowed foundation that supports Saint Mary's and the other Saint Mary's Controlled Subsidiaries. NE-RHM will consider regional fundraising opportunities and the role of the Foundation in connection with those activities. Saint Mary's will continue to comply with any donor restrictions applicable to charitable remainder trusts, donor restricted endowment funds, and other funds heretofore or hereafter donated to the Foundation.

**Section 3.10 Participation in NE-RHM and Trinity Health Services and Initiatives.**

(a) As part of the Regional Health Ministry, as soon as practicable after the Effective Date, Saint Mary's, through NE-RHM, will participate in Trinity Health services and initiatives (*e.g.*, financing, professional liability and other insurances, retirement and benefit programs, information technology, supply chain, cash management, compliance, and clinical quality initiatives, etc.) in the same manner as other NE-RHM members.

(b) NE-RHM will be charged standard Trinity Health system overhead and system services allocations to which other RHMs/RHM subsidiaries are subject. NE-RHM will, in turn, allocate those amounts to Saint Mary's and other entities within NE-RHM. Notwithstanding the foregoing, if the Effective Date occurs within one (1) year after the Saint Francis/Trinity Transfer Date, Saint Mary's, as part of NE-RHM, will not be charged standard Trinity Health system overhead until the first anniversary of the Saint Francis/Trinity Transfer Date.

**Section 3.11 Debt and Long-Term Liabilities.**

(a) Within one (1) year of the Effective Date, Trinity Health will develop a plan to address the third party debt of Saint Mary's and, to the extent possible, restructure the debt into

the Trinity Health system debt program and intercompany loan program. The Saint Mary's third party debt will remain on the balance sheet of Saint Mary's, but, to the extent possible, it will be replaced with intercompany debt to Trinity Health, provided that the terms of the existing debt and current rates of interest make that advisable. Intercompany loans from Trinity Health will be made to NE-RHM and allocated to Saint Mary's by NE-RHM. To the extent that any current Saint Mary's third party debt cannot be restructured into the Trinity Health system debt program, Trinity Health will exercise reasonable best efforts to ensure that such third party debt is paid by Saint Mary's.

(b) Additionally, within one year of the Effective Date, Trinity Health and Saint Mary's will agree on a plan to fully fund the Saint Mary's Retirement Plan. Upon a SMH Divestiture or other form of reorganization under which SMH is no longer an ERISA Affiliate of Trinity Health, the financial and other legal obligations owed to Saint Mary's Retirement Plan will either be assumed by the buyer/new parent or other transferee of SMH, fully funded by Trinity and/or NE-RHM, or retained by Trinity or NE-RHM (with any decision to fully fund or retain the Saint Mary's Retirement Plan's financial and other legal obligations of SMH to remain with Trinity Health in the sole discretion of Trinity/NE-RHM). If at any time SMH is unable to meet such Saint Mary's Retirement Plan's financial and other legal obligations through its operating cash flows and available funds, Trinity Health will allow NE-RHM to borrow any shortfall from the intercompany loan program in order to assure the payment of SMH's plan benefits to all participants, and so as to assure the payment by SMH of all required pension plan contributions to be paid by SMH to the Saint Mary's Retirement Plan in each future year.

(c) The Parties agree that the assets of the Foundation will not be a funding source for SMH's financial and other legal obligations owed to the Saint Mary's Retirement Plan or the Committed Capital, as defined in Section 4.01 below.

## ARTICLE IV
## CAPITAL COMMITMENT

**Section 4.01 Capital Commitment.** During the five (5) year period following the Effective Date, Trinity Health and NE-RHM will commit to spend aggregate Capital Expenditures in an amount no less than One Hundred Twenty Million dollars ($120,000,000), subject to achievement of the performance metrics described below in years four (4) and five (5), to support the operations of Saint Mary's and Saint Mary's Controlled Subsidiaries (the "Committed Capital"). The Committed Capital will be as follows:

(a) In the five (5) years following the Effective Date, One Hundred Million Dollars ($100,000,000) will be available to Saint Mary's for Capital Expenditures;

(b) In the fourth (4th) year following the Effective Date, if Saint Mary's obtains an operating cash flow margin of at least eight percent (8.0%) ("Target Margin") in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to Saint Mary's;

(c) In the fifth (5th) year following the Effective Date, if Saint Mary's obtains the Target Margin in the prior year, as determined by NE-RHM, an additional Ten Million dollars ($10,000,000) of Committed Capital will be available to SMHS;

(d) If the Target Margin is not met by Saint Mary's, the capital needs will be evaluated jointly by Trinity Health/NE-RHM and Saint Mary's subject to Trinity Health's standard capital allocation process.

Among the sources of the Committed Capital are: (i) available cash and investments generated by Saint Mary's, provided, however, any utilization of such cash and investments will be done in a manner that ensures Saint Mary's continued compliance with any applicable bond or loan covenants; (ii) financing obtained through the Trinity Health system debt program; and (iii) to the extent necessary, capital contributions from Trinity Health. Committed Capital shall be in addition to any funds the Foundation may make available to Saint Mary's for Capital Expenditures. The Saint Mary's capital plan will be approved by NE-RHM and presented to Trinity Health as required by Trinity Health's capital approval procedures. The Capital Expenditure allocation and approval process will not lower the amount of the Committed Capital or reduce Trinity Health's and NE-RHM's obligation to ensure the Committed Capital is spent during the five (5) year period.

**Section 4.02 Use of the Committed Capital.** The Committed Capital will be made available to support the capital needs of Saint Mary's and the other Saint Mary's Controlled Subsidiaries including strategic growth and infrastructure development for Saint Mary's integrated delivery system, to expand and upgrade the health care services provided by Saint Mary's, and to support Saint Mary's community health/population management initiatives as well as strategic growth including mergers, acquisitions, joint ventures and physician network development. Specific Capital Expenditures funded by the Committed Capital and the timing of such expenditures will be subject to (i) **Section 4.01**, (ii) Trinity Health system processes, and (iii) review and approval of the strategic plan and capital budgets of NE-RHM, including system management and governance approvals as set forth in the Trinity Health System Authority Matrix. The Parties agree that cash used to fund the Saint Mary's Retirement Plan will not be counted towards nor deducted from the Committed Capital.

**Section 4.03 Obligation to Repay Loans.** Loans extended through the Trinity Health system debt program and intercompany loan program to NE-RHM and allocated to Saint Mary's, whether for capital (including the Committed Capital) or otherwise, are required to be repaid consistent with the terms of such program.

**Section 4.04 Additional Capital Needs.** The Parties anticipate that Saint Mary's also may propose large-scale, strategic merger and acquisition opportunities for which capital needs exceed the Committed Capital. Such opportunities will be brought by Saint Mary's to NE-RHM and, if NE-RHM deems it appropriate, such opportunities will be evaluated jointly by NE-RHM and Trinity Health in connection with Trinity Health's standard capital allocation process in order to determine whether such opportunities will be supported by additional capital from Trinity Health in addition to the Committed Capital.

## ARTICLE V
## CLOSING

**Section 5.01 Closing.** Subject to the terms and conditions of this Agreement, the consummation of the transaction contemplated by this Agreement (the "**Closing**") shall take place on the last day of the month immediately after all of the conditions to Closing set forth in **Article IX** are either satisfied or waived (other than conditions which, by their nature, are to be satisfied on the Closing Date), or such other date to which the Parties mutually agree upon in writing. The date on which the Closing is to occur is herein referred to as the "**Closing Date**" and the Closing shall be effective as of 12:00:01 AM on the first day of the month immediately following the Closing Date (the "**Effective Date**").

**Section 5.02 Closing Deliverables.**

(a) At or prior to Closing, Saint Mary's shall deliver or cause to be delivered to NE-RHM the following:

(i) [Reserved];

(ii) the Amended and Restated Certificates of Incorporation of SMHS and SMH, duly filed with the Secretary of State of Connecticut to be effective as of the Effective Date, and the Amended and Restated Bylaws of SMHS and SMH effective as of the Effective Date, pursuant to which, among other things, NE-RHM will be designated as the sole member of SMHS and the holder of specified reserved powers;

(iii) the amended and restated Organizational Documents of the Saint Mary's Controlled Subsidiaries effective as of the Effective Date, with such applicable Organizational Documents duly filed with the Secretary of State of Connecticut or such other Governmental Authority as is necessary to give them effect under applicable Law;

(iv) certified copies of the resolutions of the Boards of Directors of SMHS and SMH authorizing and approving the execution of this Agreement and the transaction contemplated hereby;

(v) evidence of the approval of the Archbishop of Hartford required in connection with the execution of this Agreement and the transaction contemplated hereby in a form reasonably acceptable to Trinity Health;

(vi) documents, instruments, affidavits, indemnifications and undertakings required by the Title Company to issue the Title Policies;

(vii) Title Polic(ies) covering the Owned Real Property in accordance with **Section 8.08** in a form and substance satisfactory to NE-RHM and Trinity Health;

(viii) a list of the officers and directors of SMHS and SMH as of the Closing Date certified by an appropriate officer of Saint Mary's, as applicable;

(ix) written resignations, effective as of the Effective Date, of the officers and directors of SMHS and SMH;

(x) evidence of all church and canonical approvals required in connection with the alienation of property arising from the transactions; and

(xi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Trinity Health and NE-RHM, as may be required to give effect to this Agreement.

(b) At the Closing, NE-RHM shall deliver to Saint Mary's the following:

(i) documents, instruments, affidavits, indemnifications and undertakings, if any, required by the Title Company to issue the Title Policies;

(ii) certified copies of resolutions of NE-RHM's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

(c) At the Closing, Trinity Health shall deliver to Saint Mary's the following:

(i) certified copies of any resolutions of Trinity Health's governing body authorizing and approving the execution of this Agreement and the transaction contemplated hereby which are required under the Trinity Health System Authority Matrix; and

(ii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

## ARTICLE VI
### REPRESENTATIONS AND WARRANTIES OF SAINT MARY'S

Except as set forth in the Disclosure Schedules or as otherwise set forth below, Saint Mary's represents and warrants to NE-RHM and Trinity Health that the statements contained in this **Article VI** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by Saint Mary's prior to the Closing Date.

**Section 6.01 Organization and Corporate Authority.**

(a) Each of SMHS and SMH is a non-stock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Each of SMHS and SMH has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a Party and to perform its obligations hereunder and thereunder.

(b) Each Saint Mary's Controlled Subsidiary is duly organized and validly existing in good standing under the laws of its state of organization and has the requisite power and authority to own, lease, and operate the assets used in the conduct of its business and to carry on its business as it is now being conducted.

**Section 6.02 Tax-Exempt Status.** Each of SMHS and SMH and each Exempt Subsidiary is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, in each case as evidenced either by a determination letter from the IRS or a listing in the Official Catholic Directory. Neither SMHS nor SMH nor any Exempt Subsidiary has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax (including specifically, under Section 501(a) of the Code by virtue of being an organization described in Section 501(c)(3) of the Code and for real, personal and sales tax liability in the jurisdiction in which the organization is located) have been or may be revoked, modified or under consideration or review. Neither SMHS nor SMH nor any Exempt Subsidiary has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

**Section 6.03 Authorization and Enforceability of this Agreement.** The execution, delivery and performance of this Agreement by Saint Mary's (including the execution, delivery and performance of any Transaction Document to which it will be a party) has been duly authorized by all necessary corporate action. This Agreement has been duly executed and delivered by Saint Mary's and constitutes a valid and legally binding obligation of Saint Mary's, enforceable against Saint Mary's in accordance with its terms, subject to Applicable Exceptions.

**Section 6.04 No Conflicts; Consents.** The execution, delivery and performance by Saint Mary's of this Agreement and the other Transaction Documents to which it is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) conflict with or result in a violation or breach of, or default under, any provision of the certificate of incorporation, bylaws or other Organizational Documents of Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) except as set forth in **Schedule 6.04**, conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to Saint Mary's or the Saint Mary's Controlled Subsidiaries; (c) except as set forth in **Schedule 6.04**, (i) require the consent, notice to or other action by any Person under, (ii) conflict with, (iii) result in a violation or breach of, (iv) constitute a default or an event that, with or without notice or lapse of time or both, would constitute a default under, (v) result in the acceleration of or create in any party the right to accelerate, terminate, modify or cancel any Contract or Permit to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or a Saint Mary's Controlled Subsidiary, or to which any of the Saint Mary's Assets are subject; or (d) result in the creation or imposition of any Encumbrance other than Permitted Encumbrances on the Saint Mary's Assets, except in the case of clauses (b), (c), and (d), where the violation, breach, conflict, default, acceleration, failure to give notice, or Encumbrance would not have a Material Adverse Effect with respect to Saint Mary's. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to Saint Mary's or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of this Agreement or any of the other Transaction

Documents and the consummation of the transaction contemplated hereby and thereby, except for such matters as are set forth in **Schedule 6.04** and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to Saint Mary's.

**Section 6.05 Saint Mary's Subsidiaries.** The organizational chart attached as **Schedule 6.05** is an accurate and complete description of the ownership structure of Saint Mary's and the Saint Mary's Controlled Subsidiaries and the respective ownership interests of Saint Mary's and the Saint Mary's Controlled Subsidiaries in other Persons. Except as depicted on **Schedule 6.05**, neither Saint Mary's nor the Saint Mary's Controlled Subsidiaries have any ownership interests in any Person (other than shares of publicly traded securities or similar non-controlling interests held solely for investment purposes). The interest held by Saint Mary's and the Saint Mary's Controlled Subsidiaries in any Person was acquired in compliance with applicable Law.

**Section 6.06 Financial Statements.** Copies of the audited financial statements for Saint Mary's and each Saint Mary's Controlled Subsidiary as of September 30, for each of the years 2012, 2013, and 2014, and unaudited financial statements for each of the subsequent months available through the Signing Date (collectively the "**Financial Statements**"), have been made available to NE-RHM and Trinity Health. The Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Financial Statements fairly present in all material respects the financial condition of Saint Mary's and each Saint Mary's Controlled Subsidiary as of the respective dates they were prepared and the results of the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries for the periods indicated, subject to year-end adjustments in the case of the Financial Statements as of and for the period ending June 30, 2015. The balance sheets of Saint Mary's and each Saint Mary's Controlled Subsidiary as of June 30, 2015, are referred to herein, collectively, as the "**Balance Sheet**" and the date thereof as the "**Balance Sheet Date**."

**Section 6.07 Undisclosed Liabilities.** Except as set forth in **Schedule 6.07**, neither Saint Mary's nor any Saint Mary's Controlled Subsidiaries has any liabilities, obligations or commitments of any nature whatsoever, asserted or unasserted, known or unknown, absolute or contingent, accrued or unaccrued, matured or unmatured or otherwise, except (a) those which are adequately reflected or reserved against in the Balance Sheet as of the Balance Sheet Date and those existing on the Balance Sheet Date which are not, individually or in the aggregate, material in amount, and (b) those which have been incurred in the ordinary course of business since the Balance Sheet Date and which are not, individually or in the aggregate, material in amount.

**Section 6.08 Absence of Certain Changes, Events and Conditions.** Except as set forth in **Schedule 6.08** of the Disclosure Schedules, from the Balance Sheet Date until the Signature Date, Saint Mary's and each Saint Mary's Controlled Subsidiary have been operated in the ordinary course in all material respects and there has not been any:

(a) event, occurrence or development that has had, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

(b) amendment of the Organizational Documents of Saint Mary's or any Saint Mary's Controlled Subsidiary;

(c) issuance, sale or other disposition of, or creation of any Encumbrance on, any interests in any Saint Mary's Controlled Subsidiary, or grant of any options, warrants or other rights to purchase or obtain (including upon conversion, exchange or exercise) any interests in a Saint Mary's Controlled Subsidiary;

(d) material change in any method of accounting or accounting practice of Saint Mary's and the Saint Mary's Controlled Subsidiaries, except as required by GAAP;

(e) material change in the Saint Mary's Insurance Policies;

(f) failure to report to any insurance carrier any incidents, acts, errors or omissions that are covered by insurance, involve liability beyond any applicable deductibles, and relate to any patient services, visitors, or employees of any Saint Mary's Controlled Subsidiary;

(g) reservation of rights or denial letters received by Saint Mary's or Saint Mary's Controlled Subsidiary from any insurance carrier with respect to any claim in excess of $100,000;

(h) incurrence, assumption or guarantee of any indebtedness for borrowed money in excess of $100,000 except unsecured current obligations and liabilities incurred in the ordinary course of business;

(i) transfer, assignment, sale or other disposition of any of the assets shown or reflected in the Balance Sheet with a book value greater than $100,000 or cancellation of any debts or entitlements other than in the ordinary course of business;

(j) material damage, destruction or loss (not covered by insurance) to any Saint Mary's Asset in an amount which exceeds $100,000;

(k) any Capital Expenditure, capital investment in, or any loan to, any other Person not disclosed or reserved for in the Financial Statements by Saint Mary's or a Saint Mary's Controlled Subsidiary except in accordance with an approved capital budget or in the ordinary course of business;

(l) acceleration, termination, or cancellation of any Material Contract to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party by reason of default by Saint Mary's or such Saint Mary's Controlled Subsidiary;

(m) except for Permitted Encumbrances, imposition of any Encumbrance securing indebtedness in excess of $100,000 upon any of the Saint Mary's Assets;

(n) increase in the compensation or bonus paid or payable or in the benefits provided to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary other than increases made in the ordinary course of business (including those under existing labor agreements), grant to any employee of Saint Mary's or a Saint Mary's Controlled Subsidiary of any increase in severance or termination pay or any right to receive any severance or termination pay, or the adoption, amendment or termination of any Saint Mary's Benefit Plans, except in the ordinary course of business or to the extent required by applicable Law;

(o) adoption of any plan of merger, consolidation, reorganization, liquidation or dissolution or filing of a petition in bankruptcy under any provisions of federal or state bankruptcy Law or consent to the filing of any bankruptcy petition against it under any similar Law by Saint Mary's or a Saint Mary's Controlled Subsidiary;

(p) purchase, lease or other acquisition of the right to own, use or lease any property or assets for an amount in excess of $100,000, individually (in the case of a lease, per annum) or $1,000,000 in the aggregate (in the case of a lease, for the entire term of the lease, not including any option term) by Saint Mary's or a Saint Mary's Controlled Subsidiary, except for purchases in accordance with an approved capital budget or in the ordinary course of business;

(q) acquisition by merger or consolidation with, or by purchase of a substantial portion of the assets, stock or other equity of, or by any other manner, any business or any Person by Saint Mary's or a Saint Mary's Controlled Subsidiary; or

(r) any Contract to do any of the foregoing, or any action or omission that would result in any of the foregoing other than this Agreement.

**Section 6.09 Material Contracts.**

(a) **Schedule 6.09** of the Disclosure Schedules lists each of the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries (together with the Contracts described in **Section 6.09(b)** below, the "**Material Contracts**"):

(i) each Contract involving aggregate consideration in excess of $100,000;

(ii) all Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000;

(iii) all Contracts with any Governmental Authority;

(iv) any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement;

(v) all Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand;

(vi) all collective bargaining agreements or Contracts with any a union, works council or labor organization to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party; and

(vii) except for agreements relating to trade receivables, all Contracts relating to indebtedness (including, without limitation, guarantees), in each case having an outstanding principal amount in excess of $100,000.

(b) Saint Mary's has provided to Trinity Health the following Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries:

(i) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any physician or physician-owned entity or medical group practice;

(ii) any managed care agreements;

(iii) any agreements between Saint Mary's or a Saint Mary's Controlled Subsidiary and any Person who is an officer, director or employee of Saint Mary's or a Saint Mary's Controlled Subsidiary; and

(iv) all Contracts that limit or purport to limit the ability of Saint Mary's or a Saint Mary's Controlled Subsidiary to compete in any line of business or with any Person or in any geographic area or during any period of time.

(c) Except as set forth in **Schedule 6.09(c),** and except to the extent that the inaccuracy of any of the following statements would not have a Material Adverse Effect with respect to Saint Mary's: (i) each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect; (ii) to the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and (iii) no event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder. Complete and correct copies of each Material Contract (including all modifications, amendments and supplements thereto and waivers thereunder) have been made available to Trinity Health.

(d) Saint Mary's has made copies of all of the Material Contracts available to Trinity Health and NE-RHM through the MediTract on-line database.

**Section 6.10 Title to Saint Mary's Assets.**

(a) Either Saint Mary's or a Saint Mary's Controlled Subsidiary has good and valid title to, or a valid leasehold interest in, the Saint Mary's Assets, except for such imperfections as would not result in a Material Adverse Effect with respect to Saint Mary's. All of the Saint Mary's Assets (including leasehold interests) are free and clear of Encumbrances except for Permitted Encumbrances. All of the material tangible Saint Mary's Assets, whether owned or leased, are in the possession or control of Saint Mary's or a Saint Mary's Controlled Subsidiary.

(b) For the purposes of this Agreement, "**Permitted Encumbrances**" means the following:

(i) those items set forth in **Schedule 6.10**;

(ii) liens for Taxes not yet due and payable or which are being diligently contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's;

(iii) rights of way, zoning ordinances and other encumbrances affecting the Owned Real Property which do not, individually or in the aggregate, materially adversely affect the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries, or prohibit or interfere with the current operation of any Owned Real Property, or adversely affect title or the marketability of any Owned Real Property and which are otherwise acceptable to Trinity Health in its commercially reasonable judgment;

(iv) other than with respect to Owned Real Property, liens arising under original purchase price conditional sales contracts and equipment leases with third parties entered into in the ordinary course of business which are not, individually or in the aggregate, material to the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(v) statutory liens of landlords and liens of carriers, warehousemen, bailees, mechanics, materialmen and other like liens imposed by law, created in the ordinary course of business and for amounts not yet due (or which are being contested in good faith, by appropriate proceedings or other appropriate actions which are sufficient to prevent imminent foreclosure of such liens) and with respect to which adequate reserves or other appropriate provisions are being maintained by Saint Mary's; and

(vi) pledges or deposits made (and the liens thereon) in the ordinary course of business of Saint Mary's (including, without limitation, security deposits for leases, indemnity bonds, surety bonds and appeal bonds) in connection with workers' compensation, unemployment insurance and other types of social security benefits and deposits securing liability to insurance carriers under insurance or self-insurance arrangements or to secure the performance of tenders, bids, contracts (other than for the repayment or guarantee of borrowed money or purchase money obligations), statutory obligations and other similar obligations.

**Section 6.11 Condition and Sufficiency of the Saint Mary's Assets.** Subject to ordinary wear and tear and matters contemplated in Saint Mary's capital replacement plans adopted in the ordinary course of business from time to time, the buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property included in the Saint Mary's Assets are in good operating condition and repair, and are adequate for the uses to which they are being put, and none of such buildings, plants, structures, furniture, fixtures, machinery, equipment, vehicles and other items of tangible personal property is in need of maintenance or repairs except for ordinary, routine maintenance and repairs that are not material in nature or cost. The Saint Mary's Assets are sufficient for the continued conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries after the Effective Date in substantially the same manner as conducted prior to the Effective Date and constitute all of the rights, property and assets necessary to conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries other than as set forth in **Schedule 6.11**.

**Section 6.12 Real Property.**

(a) **Schedule 6.12(a)** of the Disclosure Schedules sets forth a list of all real property owned by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Owned Real Property**"). Saint Mary's or a Saint Mary's Controlled Subsidiary has good and marketable fee simple title to the Owned Real Property, free and clear of all Encumbrances, except (A) Permitted

Encumbrances and (B) those Encumbrances set forth in **Schedule 6.12(a)** of the Disclosure Schedules.

(b) **Schedule 6.12(b)** of the Disclosure Schedules sets forth a list of all real property leased by Saint Mary's or a Saint Mary's Controlled Subsidiary (collectively, the "**Leased Real Property**"), and a list of all leases for the Saint Mary's Owned Real Property (collectively, the "**Saint Mary's Leases**").

(c) Neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has received any written notice of existing, pending or threatened (i) condemnation proceedings affecting the Owned Real Property, or (ii) zoning, building code or other moratorium proceedings, or matters which would reasonably be expected to materially and adversely affect the ability to operate the Owned Real Property as currently operated. Neither the whole nor any material portion of any Owned Real Property has been damaged or destroyed by fire or other casualty.

**Section 6.13 Intangible Personal Property; Software.**

(a) Saint Mary's has disclosed to NE-RHM and Trinity Health all patents, copyrights, trademarks, service marks, trade names or other items of intellectual property registered by Saint Mary's or a Saint Mary's Controlled Subsidiary with any Governmental Authority. Saint Mary's and each Saint Mary's Controlled Subsidiary own or hold adequate licenses or other rights to use all intellectual property used in or necessary for the operation of its business as now conducted.

(b) To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is infringing any patent, trade name, trademark, service mark, copyright, trade secret, technology, know-how, or process belonging to any other Person. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of any such claim of infringement and, to the Knowledge of Saint Mary's, no actions have been instituted or are pending or threatened, which challenge the validity of the ownership or use by Saint Mary's or any Saint Mary's Controlled Subsidiary of any intellectual property used in connection with the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(c) To the Knowledge of Saint Mary's, the use by Saint Mary's or Saint Mary's Controlled Subsidiary of any third-party software in connection with such party's business operations does not conflict with, misappropriate or infringe upon the rights or ownership interests of any other Person.

**Section 6.14 Legal Proceedings; Governmental Orders.**

(a) Except as set forth in **Schedule 6.14(a)** of the Disclosure Schedules, there are no actions, suits, claims, investigations or other legal proceedings pending or, to the Knowledge of Saint Mary's, threatened (i) against or by Saint Mary's or a Saint Mary's Controlled Subsidiary that are not covered in full (subject to standard deductibles) under insurance policies and, to the extent not covered by insurance, exceed $100,000 in alleged liability; or (ii) against or by Saint Mary's or any Saint Mary's Controlled Subsidiary that challenges or seeks to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred or circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim,

investigation or other legal proceeding, except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect.

(b) Except as set forth in **Schedule 6.14(b)** of the Disclosure Schedules, there are no outstanding Governmental Orders and no unsatisfied judgments, penalties or awards against or affecting Saint Mary's or any Saint Mary's Controlled Subsidiary, except for such Governmental Orders, unsatisfied judgments, penalties or awards that would not, in the aggregate, have a Material Adverse Effect. Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with the terms of each Governmental Order set forth in **Schedule 6.14(b)** of the Disclosure Schedules, except to the extent that non-compliance would not result in a Material Adverse Effect. No event has occurred or circumstances exist that may constitute or result in (with or without notice or lapse of time) a violation of any such Governmental Order except for violations that would not in the aggregate result in a Material Adverse Effect.

**Section 6.15 Compliance with Laws; Permits.**

(a) Except as set forth in **Schedule 6.15(a)** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary are in material compliance with all Laws applicable to the business, properties and assets of Saint Mary's and the Saint Mary's Controlled Subsidiaries including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received notice of any violation of any such Laws nor, to the Knowledge of Saint Mary's, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for Saint Mary's and the Saint Mary's Controlled Subsidiaries to conduct their business as currently conducted or for the ownership and use of the Saint Mary's Assets have been obtained by Saint Mary's and the Saint Mary's Controlled Subsidiaries and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect. All fees and charges with respect to such Permits have been paid in full. Saint Mary's has disclosed to NE-RHM and Trinity Health all current material Permits issued to Saint Mary's and the Saint Mary's Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of the Saint Mary's Assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any material Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) Saint Mary's has made available to NE-RHM and Trinity Health pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the Saint Mary's Controlled Subsidiaries. SMH is in compliance in all material respects with applicable fire code regulations. SMH has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that

such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to the Saint Mary's Controlled Subsidiaries which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the Saint Mary's Controlled Subsidiaries with respect to any patient complaints have been paid in full.

(e) None of the representations and warranties in **Section 6.15** shall be deemed to relate to environmental matters (which are governed by **Section 6.21**), employee benefits matters (which are governed by **Section 6.22**), employment matters (which are governed by **Section 6.23**) or tax matters (which are governed by **Section 6.24**).

**Section 6.16 Medicare Participation/Accreditation**

(a) The Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures are eligible without restriction for participation in the Medicare, Medicaid and TRICARE plan programs (collectively, the "**Government Programs**") and have current and valid provider contracts with the Government Programs. To the Knowledge of Saint Mary's, the Saint Mary's Providers and the Joint Ventures are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of Saint Mary's, threatened, any proceeding or investigation under the Government Programs involving the Saint Mary's Providers or the Joint Ventures. Saint Mary's has made available to Trinity Health true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which the Saint Mary's Providers and the Joint Ventures were required to submit in response to such surveys and, except as set forth in **Schedule 6.16(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, each of the Joint Ventures has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of Saint Mary's, all of such cost reports filed by the Saint Mary's Providers and the Joint Ventures are complete and correct in all material respects and such cost reports do not claim, and none of Saint Mary's Providers or, to the Knowledge of Saint Mary's, either of the Joint Ventures have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and complete copies of all such cost reports for the three (3) most recent fiscal years of the Saint Mary's Providers and the Joint Ventures have been furnished to Trinity Health. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 6.16(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures.

(c) The billing practices of the Saint Mary's Providers and, to the Knowledge of Saint Mary's, the Joint Ventures with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of Saint Mary's, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

(d) SMH is duly accredited with no material contingencies by the Joint Commission or by any other accrediting bodies. Saint Mary's has made available to NE-RHM and Trinity Health each accreditation survey report and deficiency list prepared by the Joint Commission for the past three (3) years and except as set forth on **Schedule 6.16(d)** each of the Saint Mary's Providers' and Joint Ventures' most recent statement of deficiencies and plan of correction, all of which have been accepted by the accrediting body and have been implemented or are in the process of being implemented.

**Section 6.17 Compliance Programs**

(a) To the Knowledge of Saint Mary's, during the past five (5) years, each of the Saint Mary's Providers and Joint Ventures has maintained and adhered to in all material respects a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards applicable to the operations of the Saint Mary's Providers and Joint Ventures, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by Saint Mary's or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received written notice that (i) any Person providing services under a Contract with Saint Mary's or a Saint Mary's Controlled Subsidiary or (ii) any employee, contractor, or medical staff member performing services for Saint Mary's or a Saint Mary's Controlled Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) Saint Mary's has made available to NE-RHM and Trinity Health all records, audit reports and logs maintained by or behalf of the Saint Mary's Providers and the Joint Ventures in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to NE-RHM and Trinity Health, to the Knowledge of Saint Mary's, there are no actual or potential violations by the Saint Mary's Providers or the Joint Ventures or any of their respective directors, officers or employees of any

Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

**Section 6.18 Corporate Integrity Agreements.** Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, (ii) has reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of Saint Mary's, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of Saint Mary's, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of Saint Mary's, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by the Saint Mary's, that Saint Mary's or any Saint Mary's Controlled Subsidiary, or any of their directors, officers, or employees has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

**Section 6.19 HIPAA.** To the Knowledge of Saint Mary's, each Saint Mary's Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. Except as previously disclosed in writing by Saint Mary's to NE-RHM and Trinity Health, none of Saint Mary's or any Saint Mary's Controlled Subsidiary has been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by Saint Mary's or a Saint Mary's Controlled Subsidiary pursuant to HIPAA is set forth on **Schedule 6.19**.

**Section 6.20 Affiliate Transactions.** Except as disclosed in **Schedule 6.20**:

(a) To the Knowledge of Saint Mary's, no officer or director of Saint Mary's or any Saint Mary's Controlled Subsidiary ("**Interested Person**") directly or indirectly (i) owns any interest in any corporation, partnership, proprietorship or other entity which sells to or purchases products or services from Saint Mary's or any Saint Mary's Controlled Subsidiary, (ii) has any cause of action or claim against Saint Mary's or any Saint Mary's Controlled Subsidiary, or (iii) holds a beneficial interest in any Contract to which Saint Mary's or any Saint Mary's Controlled Subsidiary is a party or by which Saint Mary's or any Saint Mary's Controlled Subsidiary may be bound;

(b) None of Saint Mary's or any Saint Mary's Controlled Subsidiary is indebted, either directly or indirectly, to any Interested Person in any amount whatsoever, other than current obligations for payments of fees, salaries, bonuses and other fringe benefits for past services rendered; and

(c) No Interested Person is indebted to Saint Mary's or any Saint Mary's Controlled Subsidiary.

**Section 6.21 Environmental Matters.**

(a) To the Knowledge of Saint Mary's, except as disclosed in the reports described in subsection (e) below, the operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all Environmental Laws. To the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received from any Person in the past 10 years any: (i) Environmental Notice or Environmental Claim; or (ii) written request for information pursuant to Environmental Law, which, in each case, either remains pending or unresolved, or is the source of ongoing obligations or requirements as of the Closing Date.

(b) To Saint Mary's' Knowledge, Saint Mary's and the Saint Mary's Controlled Subsidiaries have obtained and are in material compliance with all material Environmental Permits necessary for the conduct of business of Saint Mary's and the Saint Mary's Controlled Subsidiaries as currently conducted or the ownership, lease, operation or use of the Saint Mary's Assets.

(c) None of the Owned Real Property is listed on, or has been proposed for listing on, the National Priorities List (or CERCLIS) under CERCLA, or any similar state list.

(d) To Saint Mary's' Knowledge, except as disclosed in the reports described in subsection (e) below, there has been no Release of Hazardous Materials in contravention of Environmental Law with respect to the Saint Mary's Assets or any Owned Real Property, and neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any Environmental Notice that any of the Saint Mary's Assets or Owned Real Property has been contaminated with any Hazardous Material which would reasonably be expected to result in an Environmental Claim against, or a violation of Environmental Law or term of any Environmental Permit by, Saint Mary's or a Saint Mary's Controlled Subsidiary.

(e) **Section 6.21(e)** of the Disclosure Schedules lists all material environmental reports with respect to the Saint Mary's Assets or any Owned Real Property that are in the possession or control of Saint Mary's.

(f) The representations and warranties set forth in this **Section 6.21** are the sole and exclusive representations and warranties of Saint Mary's regarding environmental matters.

**Section 6.22 Employee Benefit Matters.**

(a) **Schedule 6.22(a)** of the Disclosure Schedules includes a complete list of each "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) and each other material compensatory, pension, retirement, thrift savings, profit-sharing, bonus, stock option, stock purchase, stock ownership, equity, stock appreciation right, restricted stock, "phantom" stock, employee stock ownership, severance, deferred compensation, excess benefit, supplemental retirement, supplemental unemployment, change in control, employment, post-retirement medical or life insurance, welfare, incentive, sick leave, fringe benefit, paid time off, vacation, retention, education/tuition assistance, relocation assistance, disability, medical, hospitalization, life

insurance, other insurance or employee benefit plan, program, policy, agreement or arrangement of any kind, whether or not subject to ERISA, whether formal or informal, covering one or more persons, oral or written, that applies to any current or former employees, directors, owners or service providers or their spouses, dependents or beneficiaries or under which any such Person is or may become (assuming any vesting, performance or other benefit requirements are met) entitled to benefit (whether or not contingent) that is maintained, sponsored, contributed to, or required to be maintained or contributed to by Saint Mary's or a Saint Mary's Controlled Subsidiary, or with respect to which Saint Mary's or a Saint Mary's Controlled Subsidiary has any present liability (as stated in **Schedule 6.22(a)** of the Disclosure Schedules, each, a "**Saint Mary's Benefit Plan**"). For the avoidance of any doubt, the term "Saint Mary's Benefit Plan" includes Saint Mary's Retirement Plan unless such Retirement Plan is excluded from the term "Saint Mary's Benefit Plan." In addition, where reference is made herein to Saint Mary's Retirement Plan, it is a reference to such Plan alone, and not to other Saint Mary's Benefits Plans.

With respect to each Saint Mary's Benefit Plan, except as disclosed on **Schedule 6.22(a)**, Saint Mary's has provided to Trinity Health a true, correct and complete copy of the following documents (if applicable): (i) each writing constituting all or any part of such Saint Mary's Benefit Plan, including all plan documents and amendments thereto (or, with respect to any unwritten Saint Mary's Benefit Plans, accurate descriptions thereof); (ii) any trust agreement, insurance contract, annuity contract, voluntary employees' beneficiary association as defined in Section 501(c)(9) of the Code, or other funding instrument related to such Saint Mary's Benefit Plan; (iii) the three most recent annual reports (Forms 5500 series), including all schedules and audited financial statements attached thereto, if any; (iv) the two most recent actuarial reports; (v) the current summary plan description, any summary of material modifications thereto, and any other material employee communications provided within the last three (3) years measured from the date hereof; (vi) any notices to or other material communications with any participants or any Governmental Authority, commission or regulatory body relative to the Saint Mary's Benefit Plan in the past three (3) years; (vii) the most recent determination letter or opinion letter issued by the IRS, if any; (viii) all rulings, no-action letters or advisory opinions from the IRS, U.S. Department of Labor, the Pension Benefit Guarantee Corporation ("**PBGC**"), or any other federal or state authority that pertain to any Saint Mary's Retirement Plan and any open requests therefore; and (ix) the Form PBGC-1 filed for each of the three most recent plan years, if such forms exist. Except as specifically provided in the foregoing documents provided to NE-RHM and Trinity Health, there are no amendments to any Saint Mary's Benefit Plan that have been adopted or approved.

(b) Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan has been established, maintained, operated, and administered, in all material respects, in accordance with its terms and with all applicable Laws (including ERISA, if applicable, and the Code and the regulations promulgated thereunder) and the terms of all collectively bargaining agreements. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, each Saint Mary's Benefit Plan that is intended to be qualified under Section 401(a) of the Code has been timely amended for all applicable legal requirements in order to maintain such tax-qualified status, is subject to a current favorable determination letter, or may rely upon an opinion or advisory letter, issued by the IRS with respect to such Saint Mary's Benefit Plan, and no such favorable determination letter or opinion letter has been revoked (or to the Knowledge of Saint Mary's has revocation been threatened) and there are no existing circumstances nor to the

Knowledge of Saint Mary's have any events occurred since the date of the most recent determination letter or opinion letter that could adversely affect the tax-qualified status of any such Saint Mary's Benefit Plan or the related trust or increase the costs relating thereto. Except as listed in **Schedule 6.22(b)** of the Disclosure Schedules, with respect to each such Saint Mary's Benefit Plan that is not in the form of a volume submitter or prototype plan, the current favorable determination letter evidences compliance with the most recent cumulative list of required amendments applicable to such Saint Mary's Benefit Plan, or the Saint Mary's Benefit Plan applied for such a favorable determination letter prior to the expiration of the requisite period under the applicable Treasury Regulations or IRS pronouncements, or the Saint Mary's Benefit Plan still has a remaining period of time under the applicable Treasury Regulations or IRS pronouncements in which to apply for such letter and to make any amendments necessary to obtain a favorable letter.

(c) Except as set forth in **Schedule 6.22(c)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary sponsors, maintains or contributes to, or has any obligation to contribute to, or has any liability or potential liability under or with respect to, any "employee pension benefit plan" (as defined in Section 3(2) of ERISA), that is subject to Sections 412 or 4971 of the Code, Section 302 of ERISA or Title IV of ERISA (not including any Multiemployer Plan or Multiple Employer Plan), or otherwise has any liability or potential liability under Title IV of ERISA. With respect to each plan listed in **Schedule 6.22(c)** of the Disclosure Schedule, except as set forth in **Schedule 6.22(c)** of the Disclosure Schedule: (i) such plan is not currently, and is not reasonably expected to be, in "at risk status" within the meaning of Section 430(i) of the Code or Section 303(i) of ERISA; (ii) an election has not been made under Section 430(c)(2)(D) of the Code or Section 303(c)(2)(D) of ERISA; (iii) a copy of the most recent Certification of AFTAP has been delivered or made available to Trinity Health; (iv) no reportable event within the meaning of Section 4043(c) of ERISA (for which the disclosure requirements of Regulation Section 4043.1 et seq., promulgated by the PBGC, have not been waived) has occurred since January 1, 2009, and the consummation of the transactions contemplated by this Agreement will not result in the occurrence of any such reportable event; (v) since January 1, 2009, neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has incurred any liability under Title IV of ERISA other than for the payment of premiums to the PBGC, all of which have been paid when due; (vi) since January 1, 2009, such plan has not applied for or received a waiver of the minimum funding standards imposed by Section 412 of the Code; (vii) no notice of intent to terminate the plan has been given under Section 4041 of ERISA; (viii) the PBGC has not instituted proceedings to terminate the plan or to appoint a trustee or administrator of any such plan, and no circumstances exist that constitute grounds under Title IV of ERISA for any such proceeding; (ix) for each year beginning on or after January 1, 2008, Saint Mary's, the Saint Mary's Controlled Subsidiaries or ERISA Affiliates, as applicable, has made contributions that are not less than the minimum required contribution under Section 430 of the Code; (x) there is no "amount of unfunded benefit liabilities" as defined in Section 4001(a)(18) of ERISA as of the last day of such plan's most recent fiscal year; (xi) there is not now, and there are no existing circumstances that would give rise to, any requirement for the posting of security with respect to the plan under Sections 401(a)(29) and 436(f) of the Code or the imposition of any lien on the assets of Saint Mary's or a Saint Mary's Controlled Subsidiary or one of their ERISA Affiliates under ERISA or the Code; (xii) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates

has engaged in any transaction described in Section 4069 of ERISA; (xiii) none of Saint Mary's or any Saint Mary's Controlled Subsidiary has incurred any liability for any taxes under Section 4971 of the Code; and (xiv) there is no lien pursuant to Sections 303(k) or 4068 of ERISA or Section 430(k) of the Code in favor of, or enforceable by the PBGC or any other entity with respect to any of the assets of Saint Mary's or any Saint Mary's Controlled Subsidiary. "**ERISA Affiliate**" means, with respect to any entity, trade or business, any other entity, trade or business that is or was at the relevant time a member of a group described in Section 414(b), (c), (m) or (o) of the Code or Section 4001(b)(1) of ERISA that includes or included the first entity, trade or business, or that is a member of the same "controlled group" as the first entity, trade or business pursuant to Section 4001(a)(14) of ERISA. "**Certification of AFTAP**" means the certification of an enrolled actuary meeting the requirements imposed under Treasury Regulations Section 1.436-1 that includes, without limitation, a certification of the applicable Saint Mary's Benefit Plan's "adjusted funding target attainment percentage" within the meaning of Section 436(j) of the Code.

(d) Except as listed in **Schedule 6.22(d)** of the Disclosure Schedules, none of Saint Mary's, any Saint Mary's Controlled Subsidiary or an ERISA Affiliate of Saint Mary's or a Saint Mary's Controlled Subsidiary has at any time sponsored, established, maintained, participated in, contributed to, or been obligated to contribute to, or has any liability or potential liability under or with respect to, any Multiemployer Plan or Multiple Employer Plan. A "**Multiemployer Plan**" has the meaning set forth in in Sections 3(37) and 4001(a)(3) of ERISA. A "**Multiple Employer Plan**" is a plan that has two or more contributing sponsors, at least two of whom are not under common control within the meaning of Section 4063 of ERISA and Section 413(c) of the Code. To the Knowledge of Saint Mary's, with respect to each Multiemployer Plan identified pursuant to this **Section 6.22(d)**: (i) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates has engaged in any transaction that constitutes a withdrawal under Section 4201 et seq. of ERISA; (ii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates have incurred any liability or responsibility under Title IV of ERISA, including Withdrawal Liability, or any other provision of ERISA, the Code or any other applicable Law, the liability or responsibility has been satisfied in full and all Withdrawal Liability payments have been duly and timely made; (iii) if Saint Mary's, a Saint Mary's Controlled Subsidiary or any of their ERISA Affiliates were to experience a withdrawal or partial withdrawal from such Multiemployer Plan, no Withdrawal Liability would be incurred; and (iv) neither Saint Mary's, a Saint Mary's Controlled Subsidiary nor any of their ERISA Affiliates have received any notification, nor have any reason to believe, that any such plan is in reorganization, is insolvent, has been terminated, or would be in reorganization, be insolvent or be terminated. "**Withdrawal Liability**" means liability to a Multiemployer Plan as a result of a complete or partial withdrawal from such Multiemployer Plan, as those terms are defined in Part I of Subtitle E of Title IV of ERISA.

(e) Except as listed in Schedule 6.22(e) of the Disclosure Schedules, no Saint Mary's Benefit Plan is a "church plan" as defined in Section 414(e) of the Code and Section 3(33) of ERISA that is a non-electing employee benefit plan under Section 4(b)(2) of ERISA ("**Church Plan**"). There is no pending or, to the Knowledge of Saint Mary's, threatened lawsuit, challenge or claim by any Person challenging the "church plan" status and ERISA exemption of any Saint Mary's Benefit Plan that is a Church Plan. Except as listed in Schedule 6.22(e) of the Disclosure Schedules, any Saint Mary's Plan listed in Schedule 6.22(e) that is a defined benefit pension plan is no less than 80% funded, as determined for financial accounting purposes, and except as listed

in the **Schedule 6.22(e)**, there are no other defined benefit pension plans sponsored or maintained by Saint Mary's Hospital.

(f) Except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, with respect to any Saint Mary's Benefits Plan that is an employee welfare benefit plan within the meaning of Section 3(1) of ERISA (whether or not subject thereto), (i) no such Saint Mary's Benefit Plan is funded through a "welfare benefits fund" (as such term is defined in Section 419(e) of the Code), (ii) each such Saint Mary's Benefit Plan that is a "group health plan" (as such term is defined in Section 5000(b)(1) of the Code) complies in all material respects with the applicable requirements of COBRA (or any similar state or local Law) and HIPAA (including regulations thereunder) and (iii) each such Saint Mary's Benefit Plan complies in all material respects with the applicable provisions of the Patient Protection and Affordable Care Act and the regulations thereunder, and no such plan is grandfathered thereunder. Further, except as listed in **Schedule 6.22(f)** of the Disclosure Schedules, no Saint Mary's Benefit Plan provides and none of Saint Mary's, the Saint Mary's Controlled Subsidiaries and their ERISA Affiliates maintain, contribute to or have any present or future obligation to make any contribution or payment to, or with respect to, or have any other liability with respect to any plan or other arrangement that provides health, life or other welfare-type benefits following retirement or other termination of employment (other than death benefits when termination occurs upon death) to any Person (or any spouse or other dependent thereof), other than as required under COBRA or any similar state or local Law (and for which COBRA or other continuation coverage the Person, including any spouse or dependent thereof, pays the entire cost of coverage).

(g) Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, no Saint Mary's Benefit Plan exists that could: (i) result in the payment of any money or other property to an employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary; or (ii) provide any additional rights or benefits (including funding of compensation or benefits through a trust or otherwise) to any employee providing services for Saint Mary's or a Saint Mary's Controlled Subsidiary, in either case as a result of the execution of this Agreement or the consummation of the transaction contemplated hereby (either alone or in conjunction with any other event, including as a result of any termination of employment). Except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, neither the execution of this Agreement nor the consummation of the transaction contemplated hereby will (either solely as a result thereof or as a result of such transaction in conjunction with any other event, including as a result of any termination of employment) result in any "excess parachute payments" within the meaning of Section 280G(b) of the Code being made to any employees of Saint Mary's or a Saint Mary's Controlled Subsidiary. Further, except as listed in **Schedule 6.22(g)** of the Disclosure Schedules, execution and delivery of this Agreement nor the consummation of the transaction contemplated hereby will (either alone or in conjunction with any other event, including as a result of any termination of employment), except as contemplated pursuant to the terms of this Agreement, result in (iii) the acceleration or creation of any rights of any Person to benefits under any Saint Mary's Benefit Plan (including, without limitation, the acceleration of the accrual, vesting, or time of the payment of any benefits under any Saint Mary's Benefit Plan) or the acceleration or creation of any rights under any severance, parachute, or change in control agreement; (iv) forgiveness of indebtedness; (v) any limitation on the right of Saint Mary's or a Saint Mary's Controlled Subsidiary to amend, merge, terminate or receive a reversion of assets from any Saint Mary's Benefit Plan or related trust; (vi) the forfeiture of compensation or benefits under any

Saint Mary's Benefit Plan; (vii) Saint Mary's or a Saint Mary's Controlled Subsidiary being required to make a contribution to any Saint Mary's Benefit Plan; (viii) a conflict with the terms of any Saint Mary's Benefit Plan; (ix) any Person becoming entitled to severance or termination pay; (x) the acceleration of the funding (through a grantor trust or otherwise) of compensation or benefits under any Saint Mary's Benefit Plan; (xi) any other material obligation pursuant to any Saint Mary's Benefit Plan; or (xii) any breach or violation of, or a default under, any Saint Mary's Benefit Plan.

(h) Except as listed in **Schedule 6.22(h)** of the Disclosure Schedules, to the Knowledge of Saint Mary's, there have been no Prohibited Transactions with respect to any Saint Mary's Benefit Plan that are not exempt transactions pursuant to applicable law. Except as listed in **Schedule 6.22(h)**, to the Knowledge of Saint Mary's, no fiduciary of any Saint Mary's Benefit Plan has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Saint Mary's Benefit Plan. No claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration relating to any Saint Mary's Benefit Plan (other than routine claims for benefits) is pending or, to Saint Mary's' Knowledge, threatened and, to Saint Mary's' Knowledge, no set of circumstances exists that may reasonably give rise to a claim, action, lawsuit, charge, complaint, grievance, audit, proceeding, hearing, investigation or arbitration, relating to a Saint Mary's Benefit Plan or against a Saint Mary's Benefit Plan or the assets of any of trust under any Saint Mary's Benefit Plan, other than as listed in **Schedule 6.22(h)** of the Disclosure Schedules.

(i) To the Knowledge of Saint Mary's and other than with respect to the Saint Mary's Retirement Plan, all contributions (including all employer contributions and employee salary reduction contributions) that are due have been paid within the time periods prescribed by ERISA, to the extent ERISA is applicable, and the Code, and the plan's terms, to each Saint Mary's Benefit Plan that is a retirement type benefit plan and all contributions for any period ending on or before the Closing Date that are not yet due but which are due within legally allowable periods of time after the Closing Date have been paid to each such Saint Mary's Benefit Plan or have been properly accrued in the financial statements of SMH. All premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each Saint Mary's Benefit Plan that is a welfare benefit plan or accrued.

(j) There is no matter pending (other than routine filings) with respect to any Saint Mary's Benefit Plan before the IRS, Department of Labor, PBGC, or any other Governmental Authority.

(k) To the Knowledge of Saint Mary's, and other than as listed in **Schedule 6.22(k)**, each Saint Mary's Benefit Plan that is a "nonqualified deferred compensation plan" (as defined for purposes of Section 409A(d)(1) of the Code) has (i) been maintained and operated since January 1, 2005 in good faith compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder so as to avoid any tax, penalty or interest under Section 409A of the Code and, since January 1, 2009, been in documentary and operational compliance with Section 409A of the Code and all applicable IRS guidance promulgated thereunder or (ii) as to any such plan in existence prior to January 1, 2005, not been "materially modified" (within the meaning of IRS Notice 2005-1) at any time after October 3, 2004. No amounts under any such plan have been subject to the interest and additional tax set forth under Code Section

409A(a)(1)(B). To the Knowledge of Saint Mary's, neither Saint Mary's nor a Saint Mary's Controlled Subsidiary has any actual or potential obligation to reimburse or otherwise "gross-up" any Person for the interest or additional tax set forth under Section 409A of the Code, nor has Saint Mary's or any Saint Mary's Controlled Subsidiary been obligated to report any corrections made with respect to any such Plan to any Governmental Authority.

(l) The representations and warranties set forth in this **Section 6.22** are the sole and exclusive representations and warranties of Saint Mary's regarding employee benefit matters.

**Section 6.23 Employment Matters.**

(a) Except as set forth in **Schedule 6.23** of the Disclosure Schedules, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a party to, bound by, any collective bargaining or other agreement with a labor organization representing any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary. Except as set forth in **Schedule 6.23** of the Disclosure Schedules, during the past five years, there has not been, nor, to Saint Mary's' Knowledge, has there been any threat of, any strike, slowdown, work stoppage, lockout, concerted refusal to work overtime or other similar labor activity or dispute affecting any of the employees providing services to Saint Mary's or any Saint Mary's Controlled Subsidiary.

(b) To the Knowledge of Saint Mary's, Saint Mary's and the Saint Mary's Controlled Subsidiaries are in compliance with all applicable Laws pertaining to employment and employment practices, except to the extent that non-compliance would not have a Material Adverse Effect with respect to Saint Mary's.

(c) Copies of all written employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided to NE-RHM prior to the Signature Date. Additionally, a written description of all oral employment agreements to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party have been provided NE-RHM to prior to the Signature Date.

(d) The representations and warranties set forth in this **Section 6.23** are the sole and exclusive representations and warranties of Saint Mary's regarding employment matters.

**Section 6.24 Taxes.**

(a) Except as set forth in **Schedule 6.24** of the Disclosure Schedules, Saint Mary's and each Saint Mary's Controlled Subsidiary have each filed (taking into account any valid extensions) all Tax Returns applicable to such party and the applicable party has paid all Taxes shown thereon as owing. Such Tax Returns are true, complete and correct in all respects. Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is currently the beneficiary of any extension of time within which to file any Tax Return other than extensions of time to file Tax Returns obtained in the ordinary course of business. Except as set forth in **Schedule 6.24** of the Disclosure Schedules, to the Knowledge of Saint Mary's, Saint Mary's and each Saint Mary's Controlled Subsidiary have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no material dispute or claim

concerning any Tax liability of Saint Mary's or any Saint Mary's Controlled Subsidiary either claimed or raised in writing by any Governmental Authority that has not been settled or as to which Saint Mary's has Knowledge.

(b) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary is a "foreign person" as that term is used in Treasury Regulations Section 1.1445-2.

(c) Except for certain representations related to Taxes in **Section 6.22**, the representations and warranties set forth in this **Section 6.24** are the sole and exclusive representations and warranties of Saint Mary's regarding Tax matters.

**Section 6.25 Insurance. Schedule 6.25** of the Disclosure Schedules sets forth (i) a true and complete list of all current insurance or self-insurance policies of all risk properties, including fire, liability, product liability, errors and omissions, malpractice, workers' compensation, vehicular (often referred to as automobile liability), directors' and officers' liability, employment practices, fiduciary liability and any and all other forms of insurance maintained by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary to provide insurance protection for the assets and business thereof (collectively, the "**Saint Mary's Insurance Policies**"); and (ii) a list of all pending claims and the claims history related to Saint Mary's or any Saint Mary's Controlled Subsidiary for the ten (10) year period prior to the Signature Date. To the Knowledge of Saint Mary's, there are no claims related to Saint Mary's or any Saint Mary's Controlled Subsidiary under any such Saint Mary's Insurance Policies as to which coverage has been questioned, denied or disputed or in respect of which there is an outstanding reservation of rights. During the ten (10) years prior to the date hereof, to the Knowledge of Saint Mary's, neither Saint Mary's nor any Saint Mary's Controlled Subsidiary has received any written notice of cancellation of, premium increase with respect to, or alteration of coverage under, any of such Saint Mary's Insurance Policies. All Saint Mary's Insurance Policies are in full force and effect and enforceable in accordance with their terms and have not been subject to any lapse in coverage. To the Knowledge of Saint Mary's, none of Saint Mary's or any Saint Mary's Controlled Subsidiary is in default under, or has otherwise failed to comply with, in any material respect, any provision contained in any such Saint Mary's Insurance Policies. The Saint Mary's Insurance Policies are sufficient for compliance with all applicable Laws and Contracts to which either Saint Mary's or any Saint Mary's Controlled Subsidiary is a party. True and complete copies of the Saint Mary's Insurance Policies have been made available to Trinity Health.

**Section 6.26 Medical Staff.** SMH has an open medical staff other than with respect to hospital-based service lines where the medical staff has been closed for purposes of granting an exclusive contract or otherwise. Saint Mary's has made available to NE-RHM a true and complete copy of medical staff privilege and membership application forms used by the Saint Mary's Hospitals, including a description of medical staff privileges, all current medical staff bylaws, rules and regulations, and amendments thereto, all credentials and appeals procedures not incorporated therein, and copies of all written Contracts between SMH and physicians, physician groups, or other members of its medical staff. Except as previously disclosed by Saint Mary's to NE-RHM and Trinity Health in writing, there are no pending or, to the Knowledge of Saint Mary's, threatened appeals, challenges, disciplinary or corrective actions, or disputes involving applicants, staff members, or health professionals at SMH. To the Knowledge of Saint

Mary's, no member of the medical staff of SMH (i) is currently excluded, debarred or otherwise ineligible to participate in Government Programs, (ii) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Government Programs, or (iii) is under an investigation that may result in exclusion from participation in the Government Programs.

**Section 6.27 Brokers.** Except for Hammond Hanlon Camp LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of Saint Mary's or any Saint Mary's Controlled Subsidiary.

**Section 6.28 Due Diligence.** Saint Mary's has provided or caused to be provided to NE-RHM, Trinity Health and their Representatives all information and documents regarding the business operations and facilities of Saint Mary's and the Saint Mary's Controlled Subsidiaries that have been requested by NE-RHM and Trinity Health in connection with NE-RHM's and Trinity Health's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, Saint Mary's acknowledges and agrees that the representations and warranties set forth in this **Article VI** apply with full force and effect regardless of any due diligence investigation conducted by NE-RHM, Trinity Health, or their Representatives, prior to the Closing Date.

**Section 6.29 Full Disclosure.** No representation or warranty by Saint Mary's in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to NE-RHM or Trinity Health by Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

**Section 6.30 No Other Representations and Warranties.** Except for the representations and warranties contained in this **Article VI** (including the related portions of the Disclosure Schedules), neither Saint Mary's nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of Saint Mary's.

## ARTICLE VII
### REPRESENTATIONS AND WARRANTIES OF NE-RHM AND TRINITY HEALTH

Except as set forth in the Disclosure Schedules or as otherwise set forth below, NE-RHM and Trinity Health, where applicable, represent and warrant to Saint Mary's that the statements contained in this **Article VII** are true and correct as of the Signature Date and will be true and correct as of the Closing Date subject to any updates in the Disclosure Schedules delivered by NE-RHM or Trinity Health prior to the Closing Date.

**Section 7.01 Organization and Corporate Authority of NE-RHM and Trinity Health.**

(a) NE-RHM is a non-stock corporation, duly organized and validly existing in good standing under the laws of Connecticut. NE-RHM has all requisite corporate power and

corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

(b) Trinity Health is a nonprofit corporation, duly organized and validly existing in good standing under the laws of the State of Indiana. Trinity Health has all requisite corporate power and corporate authority to enter into this Agreement and the other Transaction Documents to which it will be a party and to perform its obligations hereunder and thereunder.

**Section 7.02 Tax-Exempt Status.** Each of NE-RHM and Trinity Health is exempt from federal income taxation pursuant to Section 501(a) of the Code, as an organization described in Section 501(c) (3) of the Code, and is not a "private foundation" as defined in Section 509(a) of the Code, as evidenced by either a determination letter from the IRS or a listing in the Official Catholic Directory. Neither NE-RHM nor Trinity Health has within the past three (3) most recent fiscal years received any written correspondence or notice from any taxing authority that any of its exemptions from Tax have been or may be revoked, modified or under consideration or review. Neither NE-RHM nor Trinity Health has taken any action that may cause it to lose its exemption from taxation under Section 501(a) of the Code.

**Section 7.03 Authorization and Enforceability of this Agreement.** The execution, delivery and performance of this Agreement by NE-RHM and Trinity Health (including the execution, delivery and performance of any Transaction Document to which it will be a party) have been duly authorized by all necessary corporate action as required by their Organizational Documents or policies. This Agreement has been duly executed and delivered by NE-RHM and Trinity Health and constitutes a valid and legally binding obligation of each of them, enforceable against each of them in accordance with its terms, subject to Applicable Exceptions.

**Section 7.04 No Conflicts; Consents.** The execution, delivery and performance by NE-RHM and Trinity Health of this Agreement and the other Transaction Documents to which each is a party, and the consummation of the transaction contemplated hereby and thereby, do not and will not: (a) result in a violation or breach of any provision of their Organizational Documents; (b) conflict with or result in a violation or breach of any provision of any Law or Governmental Order applicable to either of them; or (c) except as set forth in **Schedule 7.04** of the Disclosure Schedules, require the consent, notice or other action by any Person under, conflict with, result in a violation or breach of, constitute a default under or result in the acceleration of any agreement to which NE-RHM or Trinity Health is a party, except in the cases of clauses (b) and (c), where the violation, breach, conflict, default, acceleration or failure to give notice would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be. No consent, approval, Permit, Governmental Order, declaration or filing with, or notice to, any Governmental Authority is required by or with respect to NE-RHM or Trinity Health in connection with the execution and delivery of this Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby, except for such filings as set forth in **Schedule 7.04** of the Disclosure Schedules and such consents, approvals, Permits, Governmental Orders, declarations, filings or notices which would not have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

**Section 7.05 Brokers.** Except for Kaufman, Hall & Associates, LLC, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in

connection with the transaction contemplated by this Agreement or any other Transaction Document based upon arrangements made by or on behalf of NE-RHM or Trinity Health.

**Section 7.06 Legal Proceedings.** There are no actions, suits, claims, investigations or other legal proceedings pending or, to NE-RHM's or Trinity Health's Knowledge, threatened against or by NE-RHM or Trinity Health or any Affiliate of either of them that challenge or seek to prevent, enjoin or otherwise delay the transaction contemplated by this Agreement. No event has occurred nor do any circumstances exist that may give rise to, or serve as a basis for, any such action, suit, claim, investigation or other legal proceeding except for such actions, suits, claims, investigations or other legal proceedings that would not, in the aggregate, have a Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be.

**Section 7.07 Financial Statements.**

(a) NE-RHM has made available to Saint Mary's copies of the audited consolidated financial statements for NE-RHM as of September 30, for each of the years 2012, 2013, and 2014 (collectively the "NE-RHM Financial Statements"). The NE-RHM Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The NE-RHM Financial Statements fairly present in all material respects the financial condition of NE-RHM and the NE-RHM Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of NE-RHM and the NE-RHM Controlled Subsidiaries for the periods indicated.

(b) Trinity Health has (i) made available the following to Saint Mary's: (1) copies of the audited consolidated financial statements for Trinity Health as of June 30, for each of the years 2012, 2013, and 2014, and (2) copies of the audited consolidated financial statements of Catholic Health East as of December 31, for each of the years 2011 and 2012, and (ii) made publicly available unaudited consolidated financial statements of Trinity Health on a quarterly basis following the end of its most recent fiscal year (collectively the "**Trinity Health Financial Statements**"). The Trinity Health Financial Statements have been prepared in accordance with GAAP applied on a consistent basis throughout the period involved. The Trinity Health Financial Statements fairly present in all material respects the financial condition of Trinity Health and the Trinity Health Controlled Subsidiaries as of the respective dates they were prepared and the results of the operations of Trinity Health and the Trinity Health Controlled Subsidiaries for the periods indicated.

**Section 7.08 Compliance with Laws; Permits.**

(a) Except as set forth in **Schedule 7.08(a)** of the Disclosure Schedules, NE-RHM and the NE-RHM Controlled Subsidiaries are in material compliance with all Laws applicable to their respective businesses, properties and assets including, without limitation, the False Claims Act (31 U.S.C. § 3729, et seq.), the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), federal and state anti-kickback statutes (including 42 U.S.C. § 1320a 7b), federal and state referral laws (including 42 U.S.C. §1395nn), criminal false claims statutes (e.g. 18 U.S.C. §§ 287 and 1001), and the Beneficiary Inducement Statute (42 U.S.C. §1320a-7a(a)(5)). NE-RHM has not received notice of any violation of any such Laws nor, to the Knowledge of NE-RHM, does there exist any facts which would provide a basis for such claims.

(b) All Permits required for NE-RHM and the NE-RHM Controlled Subsidiaries to conduct their respective businesses as currently conducted or for the ownership and use of their assets have been obtained and are valid and in full force and effect, except where the failure to obtain such Permits would not have a Material Adverse Effect with respect to NE-RHM. All fees and charges with respect to such Permits have been paid in full. NE-RHM has disclosed to Saint Mary's all current material Permits issued to NE-RHM and the NE-RHM Controlled Subsidiaries which relate to their operations as currently conducted or the ownership and use of their assets, including the names of the Permits and their respective dates of issuance and expiration. No event has occurred that, with or without notice or lapse of time or both, would reasonably be expected to result in the revocation, suspension, lapse or limitation of any such Permit except such revocations, suspensions, lapses or limitations that would not in the aggregate result in a Material Adverse Effect.

(c) NE-RHM has made available to Saint Mary's pursuant to due diligence requests a copy of the most recent state licensing reports and lists of deficiencies, if any, and the most recent fire marshal surveys and list of deficiencies, if any, for the NE-RHM Controlled Subsidiaries. Each NE-RHM Controlled Subsidiary is in compliance in all material respects with applicable fire code regulations. NE-RHM has cured or submitted a plan of correction with respect to the deficiencies noted in any such licensure surveys and fire marshal reports and shall provide documentation that such cures and/or plans of correction have been accepted by the appropriate Governmental Authority as of the Closing Date.

(d) There are no outstanding patient complaints with respect to any NE-RHM Controlled Subsidiary which have been substantiated by a Governmental Authority and which have not been cured or are not the subject of a plan of correction accepted by the applicable Governmental Authority, except such complaints as would not in the aggregate result in a Material Adverse Effect. All fines imposed, if any, against the NE-RHM Controlled Subsidiaries with respect to any patient complaints have been paid in full.

**Section 7.09 Medicare Participation/Accreditation**

(a) Each NE-RHM Provider is eligible without restriction for participation in the Government Programs and have current and valid provider contracts with the Government Programs and are each in compliance with the applicable conditions of participation for the Government Programs in all material respects. There is neither pending, nor, to the Knowledge of NE-RHM, threatened, any proceeding or investigation under the Government Programs involving any NE-RHM Provider. NE-RHM has made available to Saint Mary's true and complete copies of the most recent Government Program survey reports and all plans of correction, if any, which were required in response to such surveys and, except as set forth in **Schedule 7.09(a)** of the Disclosure Schedules, all such plans of correction have been accepted by the applicable Government Program and all have been or are in the process of being implemented.

(b) Each of the NE-RHM Providers has timely filed all required Government Program cost reports for all the fiscal years through and including the most current fiscal year. To the Knowledge of NE-RHM, all of such cost reports are complete and correct in all material respects and such cost reports do not claim, and none of the NE-RHM Providers have received, reimbursement in excess of the amounts provided by Law or any applicable agreement. True and

complete copies of all such cost reports for the three (3) most recent fiscal years of the NE-RHM Providers have been furnished to Saint Mary's. Except for routine claims for reimbursement made in the ordinary course of business and except as set forth in **Schedule 7.09(b)** of the Disclosure Schedules, there are no claims, actions or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of those providers.

(c) The billing practices of the NE-RHM Providers with respect to all third party payors, including the Government Programs and private insurance companies, have been performed in the ordinary course of business and, to the Knowledge of NE-RHM, are in compliance in all material respects with all applicable Law and billing requirements of such third party payors and Government Programs, and none of the NE-RHM Providers have knowingly billed or received any material payment or reimbursement in excess of amounts allowed by Law other than underpayments and overpayments arising in the ordinary course of business.

**Section 7.10 Compliance Programs**

(a) To the Knowledge of NE-RHM, during the past five (5) years, the NE-RHM Providers have maintained and adhered in all material respects to a compliance program designed to promote compliance with all Laws and ethical standards, to improve the quality and performance of operations, and to detect, prevent, and address violations of legal or ethical standards, as applicable.

(b) Upon hiring employees and regularly thereafter, searches of the Office of Inspector General's List of Excluded Individuals/Entities are performed by NE-RHM or its designee to confirm that all employees, independent contractors, consultants, medical staff members, and other Persons providing any services under any Contract with NE-RHM or a NE-RHM Subsidiary are not, as of the date of such search, excluded, debarred or otherwise ineligible to participate in the Government Programs. Neither NE-RHM nor any NE-RHM Subsidiary has received written notice that (i) any Person providing services under a contract with NE-RHM or any NE-RHM Subsidiary or (ii) any employee, contractor, or medical staff member performing services for NE-RHM or any NE-RHM Subsidiary is charged with or has been convicted of a criminal offense related to the Government Programs, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs or is proposed for exclusion therefrom.

(c) NE-RHM has made available to Saint Mary's all records, audit reports and logs maintained by or on behalf of the NE-RHM Providers in connection with their respective compliance programs. Except for matters set forth in such records, audit reports and logs, or as otherwise disclosed to Saint Mary's, to the Knowledge of NE-RHM, there are no actual or potential violations by any of the NE-RHM Providers or any of their directors, officers or employees of any Law applicable to the Government Programs for which criminal penalties, civil monetary penalties or exclusion may be authorized.

**Section 7.11 Corporate Integrity Agreements.** Neither NE-RHM nor any NE-RHM Controlled Subsidiary (i) is a party to a corporate integrity agreement or to a Certification of Compliance Agreement with the Office of the Inspector General of the United States Department

of Health and Human Services, (ii) has any reporting obligations pursuant to any settlement agreement entered into with any Governmental Authority, (iii) to the Knowledge of NE-RHM, is the subject of any Government Program investigation, (iv) has been a defendant in any qui tam/False Claims Act litigation, (v) to the Knowledge of NE-RHM, has been served with or received any search warrant, subpoena, civil investigation demand, contact letter or telephone or personal contact by or from any Governmental Authority, and (vi) to the Knowledge of NE-RHM, has received any complaints through any compliance "hotlines" from employees, independent contractors, vendors, physicians, or any other Persons that would indicate, based on due inquiry by NE-RHM, that NE-RHM or any NE-RHM Controlled Subsidiary, or any of their respective directors, officers, or employees, has violated any Law which has not been (or are not being) addressed in accordance with the applicable party's compliance program.

**Section 7.12 HIPAA.** To the Knowledge of NE-RHM, each NE-RHM Controlled Subsidiary that is a "**Covered Entity**" (as defined in HIPAA) is in material compliance with the applicable rules and regulations promulgated under HIPAA pursuant to 45 CFR Parts 160, 162, and 164 (subparts A, D and E) and the changes thereto imposed by HITECH. None of these entities have been the subject of an enforcement action by or resolution agreement with the U.S. Department of Health & Human Services, Office for Civil Rights or any other Governmental Authority related to HIPAA within the past three (3) years. A list of all breach notifications made by any of these entities pursuant to HIPAA is set forth on **Schedule 7.12.**

**Section 7.13 Financial Capacity.** NE-RHM and Trinity Health currently have the financial capacity to perform all of their obligations under this Agreement without any conditions or contingencies.

**Section 7.14 Due Diligence**. NE-RHM and Trinity Health have provided or caused to be provided to Saint Mary's and its Representatives all information and documents regarding the business operations and facilities of NE-RHM and Trinity Health that have been requested by Saint Mary's in connection with Saint Mary's due diligence review in connection with the transaction contemplated by this Agreement. In that regard, NE-RHM and Trinity Health acknowledge and agree that the representations and warranties set forth in this **Article VII** apply with full force and effect regardless of any due diligence investigation conducted by Saint Mary's, or its Representatives, prior to the Closing Date.

**Section 7.15 Full Disclosure.** No representation or warranty by NE-RHM or Trinity Health in this Agreement and no statement contained in the Disclosure Schedules to this Agreement or any certificate or other document furnished or to be furnished to Saint Mary's pursuant to this Agreement contains any untrue statement of a material fact, or omits to state a material fact necessary to make the statements contained therein, in light of the circumstances in which they are made, not misleading.

**Section 7.16 No Other Representations and Warranties.** Except for the representations and warranties contained in this **Article VII** (including the related portions of the Disclosure Schedules), neither NE-RHM, Trinity Health nor any other Person has made or makes any other express or implied representation or warranty, either written or oral, on behalf of NE-RHM or Trinity Health.

## ARTICLE VIII
## COVENANTS

**Section 8.01 Conduct of Operations Prior to the Effective Date.**

(a) From the Signature Date until the Effective Date, except as otherwise provided in this Agreement or consented to in writing by NE-RHM and Trinity Health (which consent shall not be unreasonably withheld, conditioned or delayed), Saint Mary's shall, and shall cause the Saint Mary's Controlled Subsidiaries to, (i) conduct the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business; and (ii) use commercially reasonable efforts to maintain and preserve intact the current organization and operations and to preserve the rights and relationships of the employees, physicians, patients, suppliers, regulators and others having relationships with Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Effective Date, except as consented to in writing by NE-RHM and Trinity Health, Saint Mary's (i) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(a), (b), (c), (o),** or **(q)** to occur, (ii) shall not take any action that would cause any of the changes, events or conditions described in **Section 6.08(d), (e), (h), (i), (k), (m), (n),** or **(p)** to occur without NE-RHM's and Trinity Health's prior written consent, which will not be unreasonably withheld, conditioned or delayed, and (iii) shall notify NE-RHM and Trinity Health of any event or condition described in **Section 6.08(f), (g), (j),** or **(l)**. Saint Mary's shall promptly notify NE-RHM and Trinity Health of any Material Adverse Effect or any events that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect.

**Section 8.02 Regional Strategy/Structure and Integration Plan.** As soon as legally permissible following the Signature Date, the Parties will begin developing the framework for an integration plan to facilitate a smooth operational and administrative transition of Saint Mary's becoming part of the Regional Health Ministry. The integration plan will identify and prioritize near-term and long-term integration and planning needs as well as strategic opportunities and operational improvements that could be developed and implemented after the Effective Date.

**Section 8.03 Access to Information.**

(a) From the date hereof until the Closing, Saint Mary's shall (a) afford NE-RHM, Trinity Health and their Representatives reasonable access to and the right to inspect all of the Real Property, properties, assets, premises, books and records, Contracts and other documents and data related to Saint Mary's and the Saint Mary's Controlled Subsidiaries; (b) furnish NE-RHM and Trinity Health and their Representatives with such financial, operating and other data and information related to Saint Mary's and the Saint Mary's Controlled Subsidiaries as NE-RHM, Trinity Health or any of their Representatives may reasonably request; and (c) instruct the Representatives of Saint Mary's to cooperate with NE-RHM and Trinity Health in their investigation of Saint Mary's and the Saint Mary's Controlled Subsidiaries; provided, however, that any such investigation shall be conducted during normal business hours upon reasonable advance notice to Saint Mary's, under the supervision of Saint Mary's' personnel and in such a manner as not to interfere with the conduct of the business of Saint Mary's and the Saint Mary's Controlled Subsidiaries.

(b) From the date hereof until the Closing, NE-RHM and Trinity Health shall furnish Saint Mary's and its Representatives with such financial, operating and other data and information as is reasonably necessary in the reasonable opinion of Saint Mary's to demonstrate NE-RHM's and Trinity Health's ability to satisfy their obligations under this Agreement.

**Section 8.04 Efforts to Consummate.** Subject to the terms and conditions of this Agreement, the Parties shall (and shall cause their respective Affiliates to) use commercially reasonable efforts to take all actions and to do all things necessary, proper or advisable to consummate the transaction contemplated by this Agreement as promptly as practicable, including using commercially reasonable efforts to (a) provide all required notices to third parties, (b) make any filing with and obtain any consent, authorization, order or approval of, or any exemption by, any Governmental Authority that is required to be made or obtained in connection with the transaction contemplated by this Agreement, including, without limitation, those required under the HSR Act and obtaining all certificates of need ("**CONs**"), as described below, (c) obtain any church and canonical approvals required in connection with the alienation of property arising from the transaction contemplated by this Agreement, (d) obtain the approval of the Archbishop of Hartford to the transaction contemplated by this Agreement, (e) obtain any consent, waiver, approval or authorization from any other third party required in order to maintain in full force and effect any of the contracts, licenses or other rights of Saint Mary's Indemnity Company, LLC, the Saint Mary's Providers, and the Joint Ventures, including hospital licenses, following the Effective Date, and (f) cause the conditions in **Article IX** applicable to it to be satisfied at or prior to Closing. Without limiting the foregoing, NE-RHM and Saint Mary's shall collaborate on the development and prosecution of a joint CON application to be filed with the State of Connecticut Office of Health Care Access ("**OHCA**") for approval of the transactions contemplated by this Agreement. The parties agree that NE-RHM will prepare the first draft of the CON application, including all documents and exhibits related thereto, which shall be subject to review by the Parties and shall be approved by Trinity Health, NE-RHM, and Saint Mary's before the final CON application is filed with OHCA.

**Section 8.05 Updated Financial Statements.** Within twenty (20) days following the end of each calendar month ending prior to the Closing Date, Saint Mary's will deliver to NE-RHM true and complete copies of the unaudited consolidated financial statements for Saint Mary's and the Saint Mary's Controlled Subsidiaries, in each case prepared in a manner consistent with the Financial Statements described in **Section 6.06** hereof, and which shall fairly present the financial condition and results of operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of, and for the month ended on, the date thereof and which shall properly reflect all liabilities incurred by Saint Mary's and the Saint Mary's Controlled Subsidiaries since the date of the Financial Statements described in **Section 6.06**. The last such updated financial statements to be delivered shall be as of and for the month ended on the day prior to the Closing Date. Additionally, Saint Mary's shall deliver to NE-RHM a copy of the audited financial statements of Saint Mary's and each Saint Mary's Controlled Subsidiary for the fiscal year ending September 30, 2015, within five (5) days of their completion.

**Section 8.06 Employment Matters.**

(a) Subject to NE-RHM's and Trinity Health's due diligence review, (i) all active employees of Saint Mary's and the Saint Mary's Controlled Subsidiaries as of the Effective Date

(the "**Saint Mary's Employees**") will retain their current employment pursuant to terms and conditions substantially similar to the terms and conditions of such employees' employment immediately prior to the Effective Date, and (ii) all current employment policies, commitments and benefit plans of Saint Mary's and the Saint Mary's Controlled Subsidiaries will remain in effect after the Effective Date until the same are amended, modified, replaced or terminated. The employment of the Saint Mary's Employees will continue to be at-will following the Effective Date and NE-RHM or a Saint Mary's Controlled Subsidiary (with the consent of NE-RHM) shall have the authority to make changes regarding the terms or conditions of employment of the Saint Mary's Employees consistent with the business needs of NE-RHM.

(b) As soon as reasonably practicable, the Saint Mary's Employees shall be provided benefits comparable to those provided to other similarly situated employees of NE-RHM. Service credit will be granted to the Saint Mary's Employees under NE-RHM or Trinity Health, as the case may be, employee benefit plans or programs including, but not limited to, any retirement, 403(b), 401(k), profit sharing, health and welfare (other than any post-employment health or post-employment welfare plan eligibility), life, disability, vacation or paid time-off, severance and similar plans of NE-RHM or of Trinity Health, as the case may be, in which the Saint Mary's Employees are eligible to participate after the Effective Date for their continuous employment with Saint Mary's or a Saint Mary's Controlled Subsidiary from their most recent hire date by Saint Mary's or a Saint Mary's Controlled Subsidiary through the Effective Date for purposes of (i) satisfying any and all eligibility and participation requirements under such plans; (ii) determining the vested status of the Saint Mary's Employees under such plans; and (iii) determining the amount and duration of any benefits under such plans to the extent that service or seniority is a consideration in calculating benefits, but no credit for any service will be required that would result in a duplication of benefits, such as pension or retirement benefits, or an accrual of such a benefit for a period of time prior to the Effective Date. Notwithstanding the foregoing, such service credit will be granted only to the extent service with NE-RHM or Trinity Health is recognized under any such plan, program, policy or arrangement, and will not be granted to the extent such service is prior to a specific date before which service would not have been credited for employees of Trinity Health. In addition, such service credit will be provided only to the extent that Saint Mary's provides to Trinity Health comprehensive and complete records of such prior service that includes the duration of service and the hours worked.

(c) No provision of this **Section 8.06** shall be treated as an amendment to any Saint Mary's Benefit Plan or any employee benefit plan, program, policy, arrangement or agreement of Trinity Health. Notwithstanding anything else contained in this **Section 8.06**, the Parties do not intend for this **Section 8.06**, or any term, provision, condition or agreement contained herein, to amend any plans or arrangements or create any rights or obligations except as between the Parties to this Agreement and no provisions of this Agreement shall constitute such an amendment to any plan or arrangement, whether directly, by implication or impliedly, or by interpretation thereof, and no past, present or future director, owner, employee or other service provider (or such Person's spouse, dependent or beneficiary) will be treated as a third-party beneficiary of this Agreement.

**Section 8.07 Insurance.**

(a) From and after the date hereof through: (i) the end of the statute of limitations period applicable to an insurable claim in the case of a "claims made" policy, and (ii) the Effective Date for an "occurrence-based" policy, Saint Mary's, on behalf of itself and each Saint Mary's Controlled Subsidiary, shall at its expense maintain or caused to be maintained in effect policies of insurance (together with evidence of paid premiums with respect to such binders) providing substantially the same coverage as in effect on the date hereof as listed on **Schedule 6.25** which insure potential liability of Saint Mary's and the Saint Mary's Controlled Subsidiaries arising from the conduct of their business operations for any acts, omissions, events, claims or occurrences arising out of or otherwise related thereto prior to the Effective Date, including, without limitation, any general liability insurance policies. In the event that Saint Mary's or an applicable Saint Mary's Controlled Subsidiary does not replace or maintain a policy that is a "claims-made" policy, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to negotiate an extended reporting period for a period of not less than the end of the applicable statute of limitations period or six (6) years, whichever is greater, following the Effective Date.

(b) Saint Mary's shall or shall cause the applicable Saint Mary's Controlled Subsidiaries to, as promptly as possible, notify such carriers of any claims affecting such policies.

(c) If any of the policies of insurance described in **Schedule 6.25** are due to expire or renew prior to the Closing Date, Saint Mary's will provide the binder of insurance that demonstrates that the policy terms and conditions have not been changed, and that the full premium has been paid, and Trinity Health shall have the right to review these policies prior to the Closing Date. Additionally, Saint Mary's will or cause the applicable Saint Mary's Controlled Subsidiary to obtain and provide tail insurance for any policy that is on a claims-made basis and provide Trinity Health with evidence of such tail insurance.

(d) For any and all insurance policies described in **Schedule 6.25** with a provision that may cause a policy to be cancelled or go into automatic "run-off" (e.g., management liability such as directors and officers, fiduciary, employment practices, and cyber) due to a change in control of ownership, Saint Mary's will provide evidence that tail, either through endorsement to an existing policy or under a separate policy affording the same terms and conditions that were in place prior to the Closing, has been purchased for a minimum of six (6) years. Such binder and evidence of payment for this tail will be presented to Trinity Health prior to the Closing Date.

**Section 8.08 Title and Survey Matters.**

(a) Prior to the Closing Date, Saint Mary's shall obtain a current title commitment (the "**Title Commitment**") issued by a national title insurance company selected by Saint Mary's but acceptable to NE-RHM (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein, with respect to the Owned Real Property listed in **Schedule 8.08(a)** (the "**Insured Real Property**"). The Title Commitment shall contain the express commitment of the Title Company to issue a standard form ALTA Owner's Title Policy (each a "**Title Policy**") in an amount equal to the allocated value of the Insured Real Property, insuring good and marketable fee simple title to such Insured Real Property with the standard printed exceptions deleted in

accordance with **Section 8.08(c)** below. Saint Mary's shall promptly upon receipt provide a copy of the Title Commitment and, upon request, each exception document to NE-RHM.

(b) NE-RHM may, at its expense, obtain current as built surveys of any parcels of Insured Real Property (each a "**Survey**"), as it elects. NE-RHM shall promptly upon its receipt furnish a copy of any Survey to Saint Mary's and to the Title Company. NE-RHM shall, with respect to each Insured Real Property, have forty-five (45) days after receipt of both the Title Commitment and copies of all documents constituting exceptions to title to such Insured Real Property and the Survey of such Insured Real Property to review such Title Commitment and Survey (each, the "**Review Period**"). If NE-RHM objects to any matters (other than Permitted Encumbrances) in the Title Commitment or Survey of the applicable Insured Real Property, NE-RHM shall notify Saint Mary's in writing prior to the expiration of the applicable Review Period. In the event NE-RHM objects to such matters contained in any Title Commitment or Survey, then Saint Mary's shall either (i) cure or cause such objections to be cured, or (ii) within fifteen (15) days following NE-RHM's notification to Saint Mary's of its objection regarding such Insured Real Property, inform NE-RHM that it is unwilling or unable to cure some or all of such objections. If Saint Mary's is unable or unwilling to cure such matters, then NE-RHM may either (A) consummate the transaction contemplated by this Agreement, in which event such uncured matters to which NE-RHM has objected shall be deemed to constitute Permitted Encumbrances, or (B) terminate this Agreement, but only if the uncured matters have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing. Notwithstanding the foregoing, the procurement by Saint Mary's of affirmative insurance coverage insuring that an exception to title reflected in the Existing Title Policies provided to NE-RHM does not materially interfere with the use or operation of the premises for its intended or current use or operation shall cause such exception to be deemed a Permitted Encumbrance.

(c) On or before the Closing Date, Saint Mary's shall cause the Title Company to issue a pro forma Title Policy (or marked Title Commitment) for the Insured Real Property. If any such pro forma or marked Title Commitment contains exceptions to title in addition to the Permitted Encumbrances for such Insured Real Property, and such additional exceptions have a material adverse effect on (1) the ownership or value of the Insured Real Property, taken as a whole, or (2) the continued use and operation of the Insured Real Property, taken as a whole, following the Closing for the same purposes as used and operated prior to Closing, then NE-RHM shall have fifteen (15) days after receipt of such pro forma or marked Title Commitment, as applicable, to object in writing to such additional exceptions, and the process set forth in the last three (3) sentences of **Section 8.08(b)** shall be followed with respect to such additional exceptions. The Title Policy, if issued, shall be issued on a standard form ALTA Owner's Title Policy with the standard printed exceptions deleted (other than the standard printed exceptions that can be removed by the Title Company based only upon an accurate survey of the property, unless NE-RHM provides the survey required by the Title Company to remove such standard printed exceptions), providing insurance in an amount equal to the allocated value of the Insured Real Property and shall insure good and marketable fee simple title to the Insured Real Property subject only to Permitted Encumbrances. At Closing, Saint Mary's shall pay the premiums for the Title Policies.

(d) NE-RHM also shall exercise good faith efforts to notify Saint Mary's within 45 days of the Signature Date of any objections that it has to related to any exceptions to title reflected in the Existing Title Policies that Saint Mary's has made available to NE-RHM as of the Signature Date as part of NE-RHM's due diligence review.

**Section 8.09 Transfer Taxes.** All transfer or similar taxes (including any penalties and interest) and recording fees of any type incurred in connection with the transfer of the Owned Real Property pursuant to this Agreement, if any, and the other Transaction Documents shall be paid in accordance with state law and practice.

**Section 8.10 Public Announcements.** Unless otherwise required by applicable Law (based upon the reasonable advice of counsel), no Party to this Agreement shall make any public announcements in respect of this Agreement or the transaction contemplated hereby or otherwise communicate with any news media without the prior written consent of the other Party (which consent shall not be unreasonably withheld or delayed), and the Parties shall cooperate as to the timing and contents of any such announcement.

**Section 8.11 Confidentiality.**

(a) "**Confidential Information**" means all confidential and proprietary information, including data, documents, agreements, files and other materials, whether disclosed orally or disclosed or accessed in written, electronic or other form or media, and whether or not marked, designated or otherwise identified as "confidential," which is obtained from or disclosed by either Party (a "**Disclosing Party**") or its Representatives to the other Party (a "**Recipient**") and its Representatives in connection with this Agreement and the transaction contemplated by this Agreement, including information relating to any Saint Mary's Benefit Plan. The term Confidential Information includes, without limitation, all Confidential Information, as such term is defined in the Confidentiality Agreement, exchanged between the Parties pursuant to the Confidentiality Agreement. The term "**Confidential Information**" does not include information that: (i) at the time of disclosure or thereafter is generally available to and known by the public (other than as a result of its disclosure directly or indirectly by the Recipient or its Representatives in violation of this Agreement); (ii) was available to the Recipient from a source other than the Disclosing Party or its Representatives, provided that such source, to the Recipient's knowledge after reasonable inquiry, is not and was not bound by a confidentiality agreement with the Disclosing Party; or (iii) has been independently acquired or developed by the Recipient without violating any of its obligations under this Agreement or the Confidentiality Agreement.

(b) The Recipient shall keep the Confidential Information strictly confidential and shall not use the Confidential Information for any purpose other than to consummate the transaction contemplated by this Agreement. The Recipient shall not disclose or permit its Representatives to disclose any Confidential Information except: (i) as permitted by this Agreement, (ii) if required by Law, but only in accordance with **Section 8.11(d)**, or (iii) to its Representatives, to the extent necessary to permit such Representatives to assist the Recipient in consummating the transaction contemplated by this Agreement; provided, that the Recipient shall require each such Representative to be bound by the terms of this Agreement to the same extent as if they were parties hereto and the Recipient shall be responsible for any breach of this Agreement by any of its Representatives.

(c) Except for such disclosure as is necessary not to be in violation of any applicable Law, Governmental Order or other similar requirement of any Governmental Authority, or except as otherwise permitted by this Agreement, the Recipient shall not, and shall not permit any of its Representatives to, without the prior written consent of the Disclosing Party, disclose to any person: (i) the fact that the Confidential Information has been made available to it or that it has received or inspected any portion of the Confidential Information, (ii) the existence or contents of this Agreement, (iii) the fact that investigations, discussions or negotiations are taking or have taken place concerning the transaction contemplated by this Agreement, including the status thereof, or (iv) any terms, conditions or other matters relating to the transaction contemplated by this Agreement.

(d) If the Recipient or any of its Representatives is required, in the written opinion of the Recipient's counsel, to disclose any Confidential Information by Law, the Recipient shall (i) take all reasonable steps to preserve the privileged nature and confidentiality of the Confidential Information, including requesting that the Confidential Information not be disclosed to non-Parties or the public; (ii) give the Disclosing Party prompt prior written notice of such request or requirement so that the Disclosing Party may seek, at its sole cost and expense, an appropriate protective order or other remedy; and (iii) cooperate with the Disclosing Party, at the Disclosing Party's sole cost and expense, to obtain such protective order. In the event that such protective order or other remedy is not obtained, the Recipient (or such other persons to whom such request is directed) will furnish only that portion of the Confidential Information which, on the advice of the Recipient's counsel, is legally required to be disclosed and, upon the Disclosing Party's request, use its best efforts to obtain assurances that confidential treatment will be accorded to such information.

(e) Following the termination of this Agreement, both Parties will, as soon as reasonably practicable, (i) return or destroy or cause to be returned or destroyed all documents or other materials furnished by one Party to the other constituting Confidential Information, together with all copies and summaries thereof in the possession or under control of the Recipient or its Representatives, and (ii) destroy materials generated by the Recipient and its Representatives that include or refer to any part of Confidential Information in the possession or control of the Recipient or its Representatives. Notwithstanding the above, both Parties may retain one (1) copy of the Confidential Information and related summaries and analyses in their secure files solely for retention purposes. The Recipient and its Representatives shall continue to be bound by their obligations of confidentiality and other obligations hereunder.

(f) To the extent that any Confidential Information includes materials subject to the attorney-client privilege, none of the Company or the Disclosing Party is waiving, and shall not be deemed to have waived or diminished, its attorney work-product protections, attorney-client privileges or similar protections and privileges as a result of disclosing any Confidential Information (including Confidential Information related to pending or threatened litigation) to the Recipient or any of its Representatives.

(g) This Agreement sets forth the entire agreement regarding the Confidential Information, and supersedes the Confidentiality Agreement, which is hereby terminated in its entirety. If this Agreement is, for any reason, terminated prior to the Closing, the provisions of this **Section 8.11** shall nonetheless continue in full force and effect.

**Section 8.12 Updated Disclosure Schedules.** Not later than ten (10) business days prior to the Closing Date, Saint Mary's and NE-RHM/Trinity Health shall disclose to each other in writing any updates, supplements, or modifications to the Disclosure Schedules for which they are responsible for under this Agreement such that the Disclosure Schedules are current through that date. Saint Mary's and NE-RHM/Trinity Health shall further update such Disclosure Schedules so that they are current through the Closing Date and are reasonably acceptable to NE-RHM/Trinity Health and Saint Mary's, as applicable.

**Section 8.13 Further Assurances.** Following the Closing, each of the Parties hereto shall, and shall cause their respective Affiliates to, execute and deliver such additional documents, instruments, conveyances and assurances and take such further actions as may be reasonably required to carry out the provisions hereof and give effect to the transaction contemplated by this Agreement and the other Transaction Documents.

**Section 8.14 No Shop.** The Parties agree that, for the period commencing upon the execution of this Agreement and ending on the effective date of any termination of this Agreement, neither Saint Mary's nor its officers, directors, employees, or agents will, directly or indirectly: (a) solicit or initiate, directly or indirectly, or encourage submission of any inquiries, proposals or offers from any potential acquirors relating to a merger, reorganization, recapitalization, consolidation or other similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof; or (b) participate in any discussions or negotiations regarding, or furnish to, any Person and information with respect to the merger, consolidation, reorganization, recapitalization or similar transaction of Saint Mary's or any disposition of the assets or membership interest of Saint Mary's, or any part thereof. Saint Mary's shall immediately notify NE-RHM and Trinity Health of any contact between Saint Mary's, its officers, directors, employees or agents, and any other Person regarding any such offer, proposal or related inquiry which proposal or inquiry are received by Saint Mary's after the execution of this Agreement and prior to the Effective Date.

## ARTICLE IX
## CONDITIONS TO CLOSING

**Section 9.01 Conditions to Obligations of NE-RHM and Trinity Health.** The obligations of NE-RHM and Trinity Health to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or NE-RHM's and Trinity Health's waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VI** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that Saint Mary's is required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to Saint Mary's, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to Saint Mary's;

(e) Saint Mary's shall have executed and delivered to NE-RHM and Trinity Health all of the documents, agreements, certificates and deliverables required to be executed or delivered by Saint Mary's pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by Saint Mary's;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either Trinity Health or Saint Mary's as a result of which Trinity Health reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Saint Mary's nor any Saint Mary's Controlled Subsidiary shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or 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 Saint Mary's or any Saint Mary's Controlled Subsidiary;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties or Government Authorities which are reasonably necessary, in the opinion of NE-RHM and Trinity Health, to effectively complete the transaction contemplated by this Agreement or to operate Saint Mary's and the Saint Mary's Controlled Subsidiaries in the ordinary course of business subsequent to the Closing Date, including all CONs, shall have been obtained or otherwise mutually addressed by NE-RHM, Trinity Health and Saint Mary's pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) NE-RHM and Trinity Health shall have received documentation, assurances, or other satisfactory evidence that the Medicare and Medicaid certifications of the Saint Mary's Providers and the Joint Ventures will continue without interruption as of and after the Effective Date and that the facilities and operations of Saint Mary's and the Saint Mary's Controlled Subsidiaries that are providers in the Government Programs as of the Signature Date shall continue to participate as providers in and be eligible to continue to receive reimbursement from the Government Programs as of and after the Effective Date;

(m) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received; and

(n) Saint Mary's shall have furnished NE-RHM and Trinity Health with:

(i) complete and accurate copies of the Disclosure Schedules for which Saint Mary's is responsible under this Agreement current as of the Closing Date that are reasonably acceptable to NE-RHM and Trinity Health; provided, however, (1) NE-RHM and Trinity Health shall exercise good faith efforts to notify Saint Mary's of any objections to the Disclosure Schedules provided as of the Signature Date by Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to NE-RHM and Trinity Health unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect;

(ii) custody of the corporate record book and all records of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iii) custody of all Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries;

(iv) custody of all keys, security codes and entry cards, and other items of information necessary to gain access to and occupy the Real Property in the normal course;

(v) certificates signed by the authorized officers of the Saint Mary's, reasonably satisfactory in form and substance to NE-RHM, certifying that (a) each covenant and agreement to be performed by Saint Mary's prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of the Saint Mary's contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(vi) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to NE-RHM and Trinity Health, as may be required to give effect to this Agreement.

**Section 9.02 Conditions Precedent to Obligations of Saint Mary's.** The obligations of Saint Mary's to consummate the transaction contemplated by this Agreement shall be subject to the fulfillment or Saint Mary's' waiver, at or prior to the Closing, of each of the following conditions:

(a) The transaction by which Trinity Health will become the corporate member of NE-RHM shall have been completed;

(b) The representations and warranties set forth in **Article VII** are true, accurate and complete in all material respects as of the Closing Date; provided, however, that any representation containing a materiality limitation must be true, accurate and complete in all respects as of the Closing Date;

(c) All of the covenants and obligations that NE-RHM and Trinity Health are required to perform or to comply with pursuant to this Agreement at or prior to the Closing Date must have been duly performed and complied with in all material respects;

(d) From the Signature Date, there shall not have occurred any Material Adverse Effect with respect to NE-RHM or Trinity Health, as the case may be, nor shall any event or events have occurred that, individually or in the aggregate, with or without the lapse of time, could be reasonably expected to result in a Material Adverse Effect with respect to NE-RHM or Trinity Health as the case may be;

(e) NE-RHM and Trinity Health shall have executed and delivered to Saint Mary's all of the documents, agreements, certificates and deliverables required to be executed or delivered by them pursuant to **Section 5.02**;

(f) All corporate approvals necessary to effectuate this Agreement and the transaction contemplated by this Agreement have been obtained by NE-RHM and Trinity Health;

(g) No action or proceeding before a court or any other governmental agency or body shall have been instituted or threatened to restrain or prohibit the transaction contemplated by this Agreement, and no Governmental Authority shall have taken any other action or made any request of either NE-RHM or Saint Mary's as a result of which Saint Mary's reasonably and in good faith deems it inadvisable to proceed with the transaction;

(h) Neither Trinity Health nor NE-RHM shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted inability to pay debts as they mature, (iv) have been adjudicated insolvent or 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 NE-RHM or Trinity Health;

(i) The filings of the Parties pursuant to the HSR Act, if any, shall have been made and the applicable waiting period and any extensions thereof shall have expired or been terminated;

(j) All material consents, waivers and estoppels of any third parties which are reasonably necessary, in the opinion of Saint Mary's, to effectively complete the transaction contemplated by this Agreement, including without limitation all CONs and other required approvals of Governmental Authorities, shall have been obtained or otherwise mutually addressed by Saint Mary's, NE-RHM and Trinity Health pursuant to a separate agreement;

(k) NE-RHM, Trinity Health and Saint Mary's shall have received documentation, assurances, or other satisfactory evidence from all Governmental Authorities that, upon the Effective Date, all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries will have been received by NE-RHM or will continue without interruption in the name of NE-RHM or in the names in which the licenses are currently issued without further action on the part of NE-RHM;

(l) All canonical approvals for Saint Mary's to consummate the transaction contemplated by this Agreement shall have been received;

(m) The Wable Employment Agreement shall have been fully executed and delivered; and

(n) NE-RHM and Trinity Health shall have furnished Saint Mary's with:

(i) complete and accurate copies of the Disclosure Schedules for which they are responsible under this Agreement current as of the Closing Date; provided, however, (1) Saint Mary's shall exercise good faith efforts to notify NE-RHM and Trinity Health of any objections to the Disclosure Schedules provided as of the Signature Date by NE-RHM and Trinity Health to Saint Mary's, and (2) all such Disclosure Schedules and any new Disclosure Schedules or updates to the Disclosure Schedules shall be deemed reasonably acceptable to Saint Mary's unless one or more matters disclosed on such Disclosure Schedules constitutes a Material Adverse Effect with respect to NE-RHM;

(ii) certificates signed by authorized officers of NE-RHM and Trinity Health, reasonably satisfactory in form and substance to Saint Mary's, certifying that (a) each covenant and agreement to be performed by NE-RHM and Trinity Health prior to or as of the Closing Date has been performed, and (b) as of the Closing Date, all of the representations and warranties by or on behalf of NE-RHM and Trinity Health contained in this Agreement are true, accurate and complete in all material respects, subject to the qualification set forth in subsection (a) above; and

(iii) such other customary instruments of transfer, assumption, filings or documents, in form and substance reasonably satisfactory to Saint Mary's, as may be required to give effect to this Agreement.

## ARTICLE X
## TERMINATION

**Section 10.01 Termination.** This Agreement may be terminated at any time prior to the Closing:

(a) by the mutual written consent of Saint Mary's, NE-RHM and Trinity Health;

(b) by NE-RHM or Trinity Health by written notice to Saint Mary's if:

(i) Neither NE-RHM nor Trinity Health is then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to

perform any representation, warranty, covenant or agreement made by Saint Mary's pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by Saint Mary's by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.01** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of NE-RHM or Trinity Health to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing;

(c) by Saint Mary's by written notice to NE-RHM and Trinity Health if:

(i) Saint Mary's is not then in material breach of any provision of this Agreement and there has been a material breach, inaccuracy in or failure to perform any representation, warranty, covenant or agreement made by NE-RHM or Trinity Health pursuant to this Agreement that would give rise to the failure of any of the conditions specified in **Article IX** and such breach, inaccuracy or failure cannot be cured by NE-RHM or Trinity Health, as the case may be, by December 31, 2016; or

(ii) any of the conditions set forth in **Section 9.02** shall not have been fulfilled by December 31, 2016, unless such failure shall be due to the failure of Saint Mary's to perform or comply with any of the covenants, agreements or conditions hereof to be performed or complied with by it prior to the Closing; or

(d) by NE-RHM, Trinity Health or Saint Mary's in the event that:

(i) there shall be any Law that makes consummation of the transaction contemplated by this Agreement illegal or otherwise prohibited; or

(ii) any Governmental Authority shall have issued a Governmental Order restraining or enjoining the transaction contemplated by this Agreement, and such Governmental Order shall have become final and non-appealable; or

(iii) the transaction by which Trinity Health will become the corporate member of NE-RHM is not completed by January 1, 2016.

**Section 10.02 Effect of Termination.** In the event of the termination of this Agreement in accordance with this Article, this Agreement shall forthwith become void and there shall be no liability on the part of any Party hereto except:

(a) as set forth in this **Article X**, **Section 8.11** and **Article XI** hereof; and

(b) that nothing herein shall relieve any Party hereto from liability for any breach of any provision hereof.

## ARTICLE XI
### MISCELLANEOUS

**Section 11.01 Survival.** None of the representations and warranties contained herein shall survive the Closing, except for any instances of fraud or intentional misrepresentation. None of the covenants or other agreements contained in this Agreement shall survive the Effective Date other than those which by their terms contemplate performance after the Effective Date, and each such surviving covenant and agreement shall survive the Effective Date for the period contemplated by its terms. Notwithstanding the foregoing, any claims asserted in good faith with reasonable specificity (to the extent known at such time) and in writing by notice from the non-breaching Party to the breaching Party prior to the expiration date of the applicable survival period shall not thereafter be barred by the expiration of such survival period and such claims shall survive until finally resolved.

**Section 11.02 Expenses.** Except as otherwise expressly provided herein (including **Section 8.09** hereof), all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transaction contemplated hereby shall be paid by the Party incurring such costs and expenses, whether or not the Closing shall have occurred. Notwithstanding the foregoing, Saint Mary's and NE-RHM agree to split equally the filing fees incurred by Saint Mary's and NE-RHM in connection with (i) any filings or submissions under the HSR Act; (ii) obtaining all CONs necessary to transfer ownership of the Saint Mary's Providers and the Joint Ventures, and (iii) obtaining all Permits required by Law to operate the licensed components of Saint Mary's and the Saint Mary's Controlled Subsidiaries following the Effective Date.

**Section 11.03 Notices.** All notices, requests, consents, claims, demands, waivers and other communications hereunder shall be in writing and shall be deemed to have been given (a) when delivered by hand (with written confirmation of receipt); (b) when received by the addressee if sent by a nationally recognized overnight courier (receipt requested); (c) on the date sent by facsimile or e-mail of a PDF document (with confirmation of transmission) if sent during normal business hours of the recipient, and on the next business day if sent after normal business hours of the recipient or (d) on the third day after the date mailed, by certified or registered mail, return receipt requested, postage prepaid. Such communications must be sent to the respective Parties at the following addresses (or at such other address for a Party as shall be specified in a notice given in accordance with this **Section 11.03**):

<u>If to Saint Mary's</u>
Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706
Attn: President and Chief Executive Officer

<u>With a copy to:</u>
Robert J. Anthony, Esq.
Brown Rudnick LLP
185 Asylum Street, 38th Floor

Hartford, Connecticut 06103

If to NE-RHM:
Saint Francis Care, Inc.
Attention: President and CEO
114 Woodland Street
Hartford, Connecticut 06105

With a copy to:
Saint Francis Care, Inc.
Attention: General Counsel
114 Woodland Street
Hartford, Connecticut 06105

If to Trinity Health:
President and CEO
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

With a copy to:
General Counsel
Trinity Health
20555 Victor Pkwy
Livonia, MI 48152

**Section 11.04 Interpretation.** For purposes of this Agreement, (a) the words "include," "includes" and "including" shall be deemed to be followed by the words "without limitation"; (b) the word "or" is not exclusive; and (c) the words "herein," "hereof," "hereby," "hereto" and "hereunder" refer to this Agreement as a whole. Unless the context otherwise requires, references herein: (a) to Articles, Sections, Disclosure Schedules and Exhibits mean the Articles and Sections of, and Disclosure Schedules and Exhibits attached to, this Agreement; (b) to an agreement, instrument or other document means such agreement, instrument or other document as amended, supplemented and modified from time to time to the extent permitted by the provisions thereof and (c) to a statute means such statute as amended from time to time and includes any successor legislation thereto and any regulations promulgated thereunder. This Agreement shall be construed without regard to any presumption or rule requiring construction or interpretation against the Party drafting an instrument or causing any instrument to be drafted. The Disclosure Schedules and Exhibits referred to herein shall be construed with, and as an integral part of, this Agreement to the same extent as if they were set forth verbatim herein.

**Section 11.05 Headings.** The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement.

**Section 11.06 Severability.** If any term or provision of this Agreement is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable

such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in a mutually acceptable manner in order that the transaction contemplated hereby be consummated as originally contemplated to the greatest extent possible.

**Section 11.07 Entire Agreement.** This Agreement and the other Transaction Documents constitute the sole and entire agreement of the Parties to this Agreement with respect to the subject matter contained herein and therein, and supersede all prior and contemporaneous representations, warranties, understandings and agreements, both written and oral, with respect to such subject matter. In the event of any inconsistency between the statements in the body of this Agreement and those in the other Transaction Documents, the Exhibits and Disclosure Schedules (other than an exception expressly set forth as such in the Disclosure Schedules), the statements in the body of this Agreement will control.

**Section 11.08 Successors and Assigns.** This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective successors and permitted assigns. No Party may assign its rights or obligations hereunder without the prior written consent of the other Parties, which consent shall not be unreasonably withheld or delayed. No assignment shall relieve the assigning Party of any of its obligations hereunder.

**Section 11.09 No Third Party Beneficiaries.** This Agreement is for the sole benefit of the Parties hereto and their respective successors and permitted assigns and nothing herein, express or implied, is intended to or shall confer upon any other Person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

**Section 11.10 Amendment and Modification; Waiver.** This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each Party hereto. No waiver by any Party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the Party so waiving. No waiver by any Party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

**Section 11.11 Governing Law; Submission to Jurisdiction.** This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without giving effect to any choice or conflict of Law provision or rule (whether of the State of Connecticut or any other jurisdiction) that would cause the application of Laws of any jurisdiction other than those of the State of Connecticut. The Parties to this Agreement irrevocably agree and consent to the exclusive jurisdiction of the courts of the State of Connecticut and the federal courts of the United States, sitting in the State of Connecticut for the adjudication of any matters arising under or in connection with this Agreement.

**Section 11.12** **Specific Performance.** The Parties agree that irreparable damage would occur if any provision of this Agreement were not performed in accordance with the terms hereof and that the Parties shall be entitled to specific performance of the terms hereof, in addition to any other remedy to which they are entitled at Law or in equity.

**Section 11.13** **Counterparts.** This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement.

**SIGNATURE PAGE FOLLOWS**

**IN WITNESS WHEREOF,** and intending to be legally bound, each of the Parties hereto has caused this Agreement to be executed as of the Signature Date.

**SAINT MARY'S HEALTH SYSTEM, INC.**

By: _____

Name: Chad W. Wable

Title: President and Chief Executive Officer

**TRINITY HEALTH CORPORATION**

By: _____

Name: James R. O'Connell

Title: Executive Vice President

**SAINT FRANCIS CARE, INC.**

By: _____

Name: Christopher M. Dadlez

Title: President and Chief Executive Officer

**EXHIBITS AND DISCLOSURE SCHEDULES TO**

**MEMBERSHIP TRANSFER AGREEMENT**

**by and among**

**TRINITY HEALTH CORPORATION**

**and**

**SAINT MARY'S HEALTH SYSTEM, INC. and**
**SAINT MARY'S HOSPITAL, INC.**

**Dated as of September 18, 2015**

## EXHIBITS

Exhibit A.....Saint Mary's Exempt Subsidiaries

Exhibit B.....Saint Mary's Controlled Subsidiaries

Exhibit C.....Trinity Health System Authority Matrix

Exhibit D.....SMH Amended and Restated Certificate of Incorporation and Amended and Restated Bylaws

# EXHIBIT A

## SAINT MARY'S EXEMPT SUBSIDIARIES

Saint Mary's Hospital, Inc.

Saint Mary's Hospital Foundation, Inc.

**EXHIBIT B**

**SAINT MARY'S CONTROLLED SUBSIDIARIES**

Saint Mary's Hospital, Inc.

Saint Mary's Physician Partners, LLC

Saint Mary's Indemnity Company, LLC

Franklin Medical Group, P.C.

Diagnostic Imaging of Southbury, LLC

Naugatuck Valley MRI, LLC

**EXHIBIT C**

**TRINITY HEALTH SYSTEM AUTHORITY MATRIX**

See attached

June 25, 2015

# TRINITY HEALTH
## System Authority Matrix

This Authority Matrix summarizes a number of important activities that might be taken by an entity within the Trinity Health System and the corresponding actions or approvals that must be taken before proceeding with such activity. Many of these actions are delegations from the Board of Trinity Health to management, to Committees of the Board of Directors of Trinity Health and to governance of entities affiliated with Trinity Health. Trinity Health has adopted the following Operating Principles which apply to these delegations:

**Unity**: We act as a unified system, recognizing the interdependency of all its parts in fulfillment of its mission and vision while promoting the strength of our ministries serving our unique communities.

**Excellence:** We seek to continually innovate and improve our performance excellence and to add value by leveraging our skill and scale.

**Simplicity and Clarity**: Local, regional and system office leadership work in partnership to make decisions in a timely and collaborative manner that takes into account the variety of interests being affected.

**Accountability:** We are flexible in shaping roles, responsibilities and accountabilities at all leadership levels of the organization.

The Trinity Health Board retains control over its statutory obligations in carrying out the purposes of the corporation as the parent of a large Catholic health system. The Board is responsible for key strategic decisions and issues that will significantly impact the Trinity Health System. Delegations are established taking into account the balance between making efficient decisions close to the business activity and the need for the board and management to oversee areas of significant impact on the system as a whole in terms of Catholic Identity, strategic direction, risk and value.

The Board has adopted a process of Mission Discernment, which is intended to ensure that in the course of making major decisions, the Mission and Core Values are used as a measure to evaluate the effect of the proposed action.

This Authority Matrix is not intended to be an exclusive listing of the various actions reserved to Trinity Health or its affiliated entities. Trinity Health may clarify these delegations through policies. State law may confer additional rights or require additional actions. Those variations will be set forth in the governing documents of the entity and prevail over any conflicting authorities described in this System Authority Matrix. Different rights may also be set forth in the terms of joint venture organizing documents or other agreements. Decisions related to those joint venture entities should be made in accordance with the organizing documents; however, decisions which exceed financial thresholds or which may, in management's judgment, affect the reputation or identity of the Trinity Health System are required to be reviewed by Trinity Health management, regardless of the minority position held by the CHE Trinity affiliate in the joint venture.

**Entities:**

Catholic Health Ministries or CHM means the public juridic person that sponsors the Trinity Health system and exercises all canonical responsibilities related to its operations, subject to certain rights retained by sponsoring congregations or public juridic persons until such time as the stable patrimony (property) under the control of those sponsoring congregations or public juridic persons is alienated (transferred) to CHM.

Trinity Health means Trinity Health Corporation, an Indiana nonprofit corporation, which is the parent of the Trinity Health System.

Trinity Health System means Trinity Health, together with its subsidiaries and affiliates.

Ministry or Ministries means any or all RHMs, NHMs, and MHMs.

Mission Health Ministry or MHM means a first tier subsidiary of Trinity Health that maintains a governing body and which has oversight of non-institutional health operations and/or grant making. A list of MHMs is set forth on Exhibit A to this Matrix.

National Health Ministry or NHM means a first tier (direct) subsidiary that maintains a governing body that has day to day management oversight of a business line throughout the Trinity Health System. A list of NHMs is set forth on Exhibit A to this Matrix.

Regional Health Ministries or RHM means a first tier (direct) subsidiary, affiliate or operating division of Trinity Health that maintains a governing body that has day to day management oversight of a designated portion of the Trinity Health System within a geographical market. A list of RHMs is set forth Exhibit A to this Matrix.

Group 1 RHM means an RHM which had a minimum total operating revenue of $300 million in the previous fiscal year or an RHM that has been selected by management for inclusion in Group 1 RHMs based on operational objectives.

Group 2 RHM means an RHM which is not a Group 1 RHM.

Second Tier Subsidiaries means subsidiaries and affiliates of Ministries.

**Actions:**

Approve means to have ultimate authority over an action. Approval includes the authority to adopt, accept, modify, disapprove or send back for further consideration an action recommended or approved by another entity in the Trinity Health System. Some actions required approval at more than one level. Final approval authority is exercised by the highest level independently of any recommendation or participation actions. If more than one entity has Approval authority, the matter may be initiated and approved by the highest level of Approval authority when permitted by law.

Participate means a timely, meaningful, collaborative and consultative process among interested parties to inform the decision under consideration.

Ratify means to confirm and adopt the act of another even if it was not approved beforehand. It also means final decision making authority, but without the power to initiate or change a recommendation.

Recommend means to review and present a matter for approval by another entity in the Trinity Health System. Recommending authority does not limit the right of the approving entity to initiate an action without a recommendation.

**Other:**

Governing documents are documents which establish and describe an entity, including the purposes, the powers reserved to the members or shareholders, and which set forth the rights of partners or joint owners relative to each other. Governing documents include documents

filed with the state (such as articles or certificates of incorporation), bylaws (whether a corporation or an unincorporated division which has its own governing body), operating agreements and partnership agreements.

Key Bylaws Provisions are variations from the standard Governing Documents that concern any of the following: (a) the Ministry name and corporate purposes; (b) the Mission, Core Values and Catholic Identity of the Ministry and powers exercisable by CHM; (c) the identity of, reserved powers exercisable by and other matters pertaining to Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Ministry Board of Directors. All other variations are not Key Bylaw Provisions.

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| **I** | **Statements of Identity** | | | | | |
| I a | Trinity Health System Mission Statement | - | - | - | | Approve |
| 1 b | Trinity Health System Core Values | - | - | - | | Approve |
| **II** | **Governing Documents** | | | | | |
| II a | Articles and Bylaws of Trinity Health Corporation | - | - | Recommend | Approve and Recommend | Ratify |
| II b | Governing Documents of Ministries consistent with standard form approved by Trinity Health Board | - | Approve and Recommend | Approve variations from the approved standard Bylaws which are not Key Bylaws Provisions (determination by the General Counsel) | Approval of Governing Documents by Executive and Governance Committee, except as to Bylaws limited to approval of variations from the approved standard which are Key Bylaws Provisions | - |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| II c | Governing Documents of Second Tier Subsidiary which operates licensed healthcare facilities consistent with standard form approved by Trinity Health Board | - | Approve and Recommend | Approve variations from the approved standard Bylaws which are not Key Bylaws Provisions (determination by the General Counsel) | Approval of Governance Documents by Executive and Governance Committee, except as to Bylaws limited to approval of variations from the approved standard which are Key Bylaws Provisions | - |
| II d | Governing Documents of Second Tier Subsidiary | Recommend | Approve | Approve | | |
| **III** | **Appointments and Removals** | | | | | |
| III a | Appointment or removal of CHM Members (which comprise the Trinity Health Board of Directors) | | | | | Approve |
| III b | Appointment or removal of Trinity Health Board Chair | | | | Approve | Ratify |
| III c | Appointment or removal Ministry Boards of Directors | | Recommend | Recommend | Approve (Executive and Governance Committee) | |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| III d | Appointment or removal of Ministry Board Chairs | | Approve | | Ratify (Executive and Governance Committee) | |
| III e | Appointment or removal of Second Tier Subsidiaries Governing Body | Recommend | Approve | | | |
| III f | Appointment or removal of Trinity Health CEO | | | | Approve | Ratify |
| III g | Appointment or removal of Ministry CEOs | Participate | Recommend | Approve | | |
| III h | Appointment or removal of Second Tier Subsidiaries CEOs | Approve | | | | |
| **IV** | **Strategy** | | | | | |
| IV a | Trinity Health System Strategic Plans | | | Recommend | Approve | |
| IV b | Group I RHM and NHM Strategic Plans | Recommend | Approve | Approve | | |
| IV c | Group 2 RHM and MHM Strategic Plans | Recommend | Approve | Participate | | |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| **V** | **Finance Matters** | | | | | |
| V a | Group I RHM and NHM Capital Acquisitions and Dispositions | Recommend | Approve up to 2% of net assets with a maximum of $5million | Approve above the RHM Governance level up to $25 million | Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee) | Approval as required by Canon Law |
| V b | Group II RHM and MHM Capital Acquisitions and Dispositions | Recommend | Approve up to 2% of net assets with a minimum of $250,000 and a maximum of $2 million | Approve above the RHM Governance level up to $25 million | Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee) | Approval as required by Canon Law |
| V c | Additional Debt and System Five Year Plan of Finance | | | Recommends | Approval up to $50 million by the Stewardship Committee and above that level by the Board (upon recommendation by Stewardship Committee) | |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| V d | System Operating and Capital Budget | | | Recommend | Approve (upon recommendation by Stewardship Committee) | |
| V e | RHM Operating and Capital Budget | Recommend | Approve | Approve | | |
| V f | Second Tier Operating and Capital Budget | Recommend | Approve | | | |
| V g | Contracts (including leases) in which the Trinity Health is the financially obligated | | | Approve up to $25 million | Approval up to $50 million by the Stewardship Committee and above that level by the Board (upon recommendation by Stewardship Committee) | |
| V h | Contracts (including leases) in which a Group I RHM or a NHM is financially obligated | Recommend | Approve up to 2% of net assets with a maximum of $5million | Approve above the RHM Governance level up to $25 million | Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee) | |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| V i | Contracts (including leases) in which a Group II RHM or MHM is financially obligated | Recommend | Approve up to 2% of net assets with a minimum of $250,000 and a maximum of $2 million | Approve above the RHM Governance level up to $25 million | Approval $25-$50 million by Stewardship Committee and above that level by Board (upon recommendation by Stewardship Committee) | |
| V j | Auditor Selection (Trinity Health System and separate audits) | | | Recommend | Approve (upon recommendation by the Audit Committee) | |
| V k | Annual Trinity Health System Audit | | | Recommend | Approve (upon recommendation by the Audit Committee) | |
| **VI** | **New Organizations and Major Transactions** | | | | | |
| VI a | Major change affecting Trinity Health (merger, consolidation, creation, transfer, sale of substantially all assets) | | | Recommend | Approve | Approve |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| VI b | Major change affecting Ministry (merger, consolidation, creation, transfer, sale of all assets) not related to an Trinity Health System reorganization | Recommend | Recommend (Approve if required by State law) | Recommend | Approve | Approve as related to Sponsorship obligations |
| VI c | Major change affecting Ministry (merger, consolidation, creation, transfer, sale of all assets) related to a Trinity Health System reorganization | Recommend | Recommend (Approve if required by State law) | Recommend | Stewardship Committee Approve | Approve as related to Sponsorship obligations |
| VI d | Major change affecting Second Tier Subsidiaries (merger, consolidation, creation, transfer, sale of all assets) | Recommend | Approve | Approve | | Approve as related to Sponsorship obligations |
| VI e | Internal operational reorganization affecting tier structure | Participate | Recommend | Approve | | |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| VI f | Formation or acquisition of an entity in which Trinity Health will be the sole parent | | | Recommend | Approve | Approve as related to Sponsorship obligations |
| VI g | Joint venture or other enterprise affecting ownership of a Group I RHM or NHM | Recommend | Approve | Recommend | Approve | Approve as related to Sponsorship obligations |
| VI h | Joint venture or other enterprise affecting ownership of a Group II RHM or MHM | Recommend | Approve | Recommend | Approval by Stewardship Committee | Approve as related to Sponsorship obligations |
| **VII** | **People Centered Care** | | | | | |
| VII a | Trinity Health System Wide Quality and Safety Standards | Participates | | Recommends | Approves (upon recommendation of the People Centered Care Committee | |

| | Action | Ministry Management | Ministry Governance | Trinity Health Management | Trinity Health Governance | Catholic Health Ministries |
|---|---|---|---|---|---|---|
| VII b | RHM Quality and Safety Standards (consistent with Trinity Health System Quality Standards) | Recommends | Approves | | | |
| VII c | Annual review of Trinity Health System Quality and Safety | | | Recommends | People Centered Care Committee Approves, Board Receives Report | |
| VII d | Annual review of RHM Quality and Safety | Recommends | Approves | Receive Report | | |

## EXIHIBIT A

## MINISTRIES
**Based on the FY 2014 Income Statement**

### REGIONAL HEALTH MINISTRIES (RHMs) – GROUP I
Holy Cross Health (Maryland)
Holy Cross Hospital (Florida)
Loyola University Health System (Illinois)
Mercy Health (Michigan)
Mercy Health Services – Iowa (Iowa)
Mercy Health System of Southeastern Pennsylvania (Pennsylvania)
Mount Carmel Health System (Ohio)
Our Lady of Lourdes Health Care Services (New Jersey)
Saint Agnes Medical Center (California)
Saint Alphonsus Health System (Idaho)
Saint Joseph Mercy Health System (Michigan)
Saint Joseph Regional Medical Center (Indiana)
Sisters of Providence Health System (Massachusetts)
St. Mary Medical Center (Pennsylvania)
St. Mary's Health Care System (Georgia)
St. Peter's Health Partners (New York)

### REGIONAL HEALTH MINISTRIES (RHMs) – GROUP II
Mercy Health System of Chicago (Illinois)
Saint James Mercy Health System (New York)
Saint Michael's Medical Center (New Jersey)
St. Francis Hospital (Delaware)
St. Francis Medical Center (New Jersey)

### NATIONAL HEALTH MINISTRIES (NHMs)
Trinity Home Health Services (multi-state)
Trinity Senior Living Communities (multi-state)
Trinity PACE

### MISSION HEALTH MINISTRIES (MHMs)
Allegany Franciscan Ministries (Florida)
Global Health Ministry (Pennsylvania)
Mercy Medical (Alabama)
Pittsburgh Mercy Health System (Pennsylvania)
Saint Joseph's Health System (Georgia)

Approved by Trinity Health Executive and Governance Committee 6/18/14, effective 7/1/14; revised and approved by the Trinity Health Executive and Governance Committee on January 27, 2015; revised and approved by the Trinity Health Board of Directors on February 25, 2015; revised and approved by the Trinity Health Executive and Governance Committee on April 9, 2015; approved by Catholic Health Ministries on June 25, 2015.

**EXHIBIT D**

**SAINT MARY'S HOSPITAL, INC. AMENDED AND RESTATED CERTIFICATE OF INCORPORATION AND AMENDED AND RESTATED BYLAWS**

[SEE ATTACHED]

**Restated Certificate of Incorporation of Saint Mary's Hospital, Inc.**

A Connecticut Nonstock Corporation

1. The present name of the Corporation is Saint Mary's Hospital, Inc., which was incorporated on April 11, 1907.

2. This Restated Certificate of Incorporation integrates and amends the previous Certificate of Incorporation and is executed pursuant to the provisions of the Connecticut Nonstock Corporation Act (the "Act"), as amended.

3. The text of the Restated Certificate of Incorporation is as follows:

## ARTICLE I

## Name

The name of the Corporation is Saint Mary's Hospital, Inc.

## ARTICLE II

## Definitions

For the purposes of this Certificate, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership (as defined in the Bylaws) of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Code of Regulations, System Authority Matrix, Bylaws or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

## ARTICLE III

## Purposes

The Corporation shall be organized and operated exclusively for religious, charitable, scientific, and educational purposes within the meaning of Section 501(c)(3) of the Code. The Corporation shall not have or issue shares of stock or make distributions. The Corporation shall have no power to act in a manner which is not exclusively within the contemplation of Section 501(c)(3) of the Code, and the Corporation shall not engage directly or indirectly in any activity which would prevent it from qualifying, and continuing to qualify, as a Corporation as described in Section 501(c)(3) of the Code. Without limiting the generality of the foregoing, the purposes for which the Corporation is organized are to advance, promote, support, and carry out the purposes of Trinity Health Corporation, an Indiana nonprofit corporation, or its successor, and to further the apostolate and charitable works of Catholic Health Ministries on behalf of and as an integral part of the Roman Catholic Church in the United States. Without limiting the generality of the foregoing, the specific purposes of the Corporation shall include the following:

A. To carry out the purposes of Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successor, which is the Member of the Corporation, and to further the apostolate of Catholic Health Ministries on

behalf of and as an integral part of the Roman Catholic Church in the United States;

B. To engage in the delivery of and to carry on, sponsor or participate, directly or through one or more affiliates, in any activities related to the delivery of health care and health care related services of every kind, nature and description which, in the opinion of the Directors of the Corporation, are appropriate in carrying out the health care mission of the Trinity Health and Catholic Health Ministries. The Corporation shall take all such actions including, but not limited to, support and assistance of affiliates, as may be necessary or desirable to accomplish the foregoing purpose within the restrictions and limitations of this Certificate of Incorporation, the Bylaws of the Corporation or applicable law, including, without limitation, promoting and carrying on scientific research and educational activities related to the care of the sick and promotion of health, and establishing, maintaining, owning, managing, operating, transferring, conveying, supporting, assisting and acquiring institutions, facilities and programs in several states, directly or through one or more affiliates, including, but not limited to, hospitals and clinics, which shall provide diagnosis and treatment to inpatients and outpatients and shall provide such support services as, but not limited to, extended care, shared services, pastoral care, home care, long-term care, operation of senior residences, care of the elderly and the handicapped, care of the economically needy, child care, social services, mental health and substance abuse services;

C. To promote, support and further any and all charitable, scientific, religious and educational purposes within the meaning of Section 501(c)(3) of the Code;

D. To coordinate and oversee the activities of Affiliates, and to allocate the assets, liabilities and resources of the Corporation and its Affiliates within the Health System;

E. To acquire, purchase, own, loan and borrow, erect, maintain, hold, use, control, manage, invest, exchange, convey, transfer, sell, mortgage, lease and rent all real and personal property of every kind and nature, which may be necessary or incidental to the accomplishment of any and all of the above purposes;

F. To accept, receive and hold, in trust or otherwise, all contributions, legacies, bequests, gifts and benefactions which may be left, made or given to the Corporation, or its predecessor or constituent corporations, by any person, persons or organizations;

G. To take all such actions as may be necessary or desirable to accomplish the foregoing purposes within the restrictions and limitations of this

Certificate of Incorporation, the Bylaws of the Corporation and applicable law, provided that no substantial part of the activities of the Corporation shall be to carry out propaganda, or to otherwise attempt to influence legislation; and the Corporation shall not participate or intervene in any political campaign on behalf of or in opposition of any candidate for public office (by the publishing or distribution of statements or otherwise), in violation of any provisions applicable to corporations exempt from taxation under Section 501(c)(3) of the Code and the regulations promulgated thereunder as they now exist or as they may be amended;

H. The Corporation shall not be operated for the pecuniary gain or profit, incidental or otherwise, of any private individual, and no part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its Directors, Officers or other private individuals, except the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for the Corporation and to make payments and distributions in furtherance of the purposes set forth herein consistent with applicable law; and

I. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any activity not permitted to be carried on by: (i) a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (ii) a corporation, contributions to which are deductible under Section 170(c)(2) of the Code; and a corporation described in Section 509(a)(3) of the Code (or, if the Corporation is classified, Section 509(a)(1) or 509(a)(2) of the Code).

## ARTICLE IV
## Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the *Ethical and Religious Directives for Catholic Health Care Services* as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time). Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

## ARTICLE V

## Organization

The Corporation is a religious corporation, organized on a non-stock basis as a membership corporation. The Corporation's sole member is Saint Francis Care, Inc., a Connecticut nonstock corporation.

## ARTICLE VI

## Registered Office and Resident Agent

The address of the Corporation's registered office is _____. The resident agent of the Corporation is _____. The address of the Corporation's registered office and/or name of the Corporation's resident agent may be changed from time to time by the Board of Directors of the Corporation.

## ARTICLE VII

## Membership

Saint Francis Care, Inc., a Connecticut nonstock corporation ("Member") is the sole member of the Corporation. The Member shall be entitled to all rights and powers of a member under Connecticut law, this Certificate of Incorporation and the Bylaws of the Corporation. Certain rights and powers related to the Corporation are reserved to the Member and Trinity Health under the Corporation's Governance Documents. Action by the Corporation shall not be taken or authorized until the Member and Trinity Health, as required, shall have exercised their respective reserved powers in the manner provided in the Governance Documents. The following powers are reserved to the Member and Trinity Health:

a. As reserved to the Member:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonstock corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

b. As reserved to Trinity Health:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in addition to any other rights reserved to Trinity Health under applicable

law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in this Certificate, or (iii) transfers in the ordinary course of business.

## ARTICLE VIII

### Indemnification and Standard of Care

Section 1. Indemnification. The Corporation shall, to the maximum extent allowed by law, indemnify those persons who are serving or have served as members, trustees, directors, religious congregations or other canonical persons serving as sponsors, officers, employees, committee members, or agents of the Corporation, and those who are serving or have served at the request of the Corporation as a trustee, director, religious congregation or other canonical person serving as sponsor, officer, manager, partner, employee, committee member, or agent of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

Section 2. Insurance. Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person who is or was a member, director, trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of the Corporation, or who is or was serving at the request of the Corporation as a trustee, religious congregation or other canonical person serving as sponsor, officer, director, committee member, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have power to indemnify him or her against such liability under state law.

Section 3. Standard of Care. Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a

member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

Section 4. Justifiable Reliance. In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

a. One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.
b. Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.
c. A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.
d. A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

Section 5. Consideration of Factors. In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

Section 6. Presumption. Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation.

Section 7. Personal Liability of Director. No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

## ARTICLE IX

### Dissolution

Subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation, upon the dissolution and final liquidation of the Corporation, all of its assets, after paying or making provision for payment of all its known debts, obligations and liabilities, and returning, transferring or conveying assets held by the Corporation conditional upon their return, transfer or conveyance upon dissolution of the Corporation, shall be distributed to the Member of this Corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any such assets not disposed of in accordance with the foregoing shall be distributed to Trinity Health Corporation, an Indiana nonprofit corporation or its successor, so long as such distributee is an organization exempt from federal income tax by virtue of being an organization as described in Section 501(c)(3) of the Code. Any assets not so disposed of in accordance with the foregoing shall be distributed to one or more corporations, trusts, funds or organizations which at the time appear in the Official Catholic Directory published annually by P.J. Kenedy & Sons or any successor publication, or are controlled by any such corporation, trust, fund or organization that so appears, and are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code, as in the sole judgment of the Catholic Health Ministries have purposes most closely aligned to those of the Corporation, subject to any approvals described in this Certificate of Incorporation or the Bylaws of the Corporation and applicable law. Any assets not so disposed of shall be disposed of by a court of competent jurisdiction exclusively to one or more corporations, trusts, funds or other organizations as said court shall determine, which at the time are exempt from federal income tax as organizations described in Section 501(c)(3) of the Code and which are organized and operated exclusively for such purposes. No private individual shall share in the distribution of any Corporation assets upon dissolution of the Corporation.

## ARTICLE X

### Effective Date of This Restated Certificate of Incorporation

This Restated Certificate of Incorporation is effective as _____, 201_.

# BYLAWS

# OF

# SAINT MARY'S HOSPITAL, INC.

# A CONNECTICUT NONSTOCK CORPORATION

Effective Date: _____, 201_

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## ARTICLE I. DEFINITIONS

For the purposes of these Bylaws, the following defined terms shall have the following meanings:

"Affiliate" means a corporation or other entity that is subject to the direct or indirect Control or Ownership of the Corporation.

"Board" or "Board of Directors" means the Board of Directors of the Corporation, and the term "Director" means an individual member of the Board.

"Catholic Health Ministries" or "CHM" means Catholic Health Ministries, a public juridic person that is the religious sponsor of the Corporation under the canon law of the Roman Catholic Church.

"Catholic Identity" means the theological, ethical, and canonical underpinnings of a Catholic-sponsored organization without which the entity cannot be considered a Roman Catholic church-related ministry.

"Certificate of Incorporation" means the Certificate of Incorporation of the Corporation, as amended or restated from time to time.

"Code" shall mean the Internal Revenue Code of 1986, as amended from time to time.

"Control" or "Ownership" will be deemed to exist:

> (i) as to a corporation: (a) through ownership of the majority of voting stock or the ownership of the class of stock which exercises reserved powers, if it is a stock corporation; or (b) through serving as member and having the power to appoint (including through appointing one's own directors or officers who then serve ex officio as to the Affiliate) the majority of the voting members or the class of members which exercises reserved powers, if it is a corporation with members; or (c) through having the power to appoint (including through appointing one's own directors or officers who then serve *ex officio* as to the Affiliate) the majority of the voting directors or trustees or the controlling class of directors or trustees, if it is a corporation without members; or
>
> (ii) as to a partnership or other joint venture: through the possession of sufficient controls over the activities of the partnership or joint venture that the entity having control is permitted to consolidate the activities of the partnership or joint venture on its financial statements under generally accepted accounting principles.

The terms "Controlled," "Controlling," "Owned" or "Owning" shall be subsumed within the definitions of "Control" or "Ownership."

"Corporation" shall mean Saint Mary's Hospital, Inc., a Connecticut nonstock corporation.

"Governance Documents" means the Articles of Incorporation, Certificate of Incorporation, Bylaws, System Authority Matrix, Code of Regulations or equivalent organizational documents of a corporation or other entity.

"Health System" or "Trinity Health System" means the health system which consists of Trinity Health and its subsidiaries and Affiliates.

"Key Bylaws Provisions" shall refer to sections of these Bylaws that concern any of the following: (a) the name and corporate purposes of the Corporation; (b) the Catholic Identity and Mission and Core Values of the Corporation and the powers exercisable by CHM; (c) the identity of, reserved powers exercisable by, and other matters pertaining to, the Member and Trinity Health; and (d) the authority and membership (including election, composition and removal) of the Board of Directors of the Corporation.

"Member" shall refer to Saint Francis Care, Inc., a Connecticut nonstock corporation which is the sole member of the Corporation.

"Operating Unit" shall have the definition set forth in Section 5.04 of these Bylaws.

"Regional Health Ministry" or "RHM" is an Affiliate or operating division within the Health System that maintains a governing body that has day to day management oversight of a designated portion of the Health System, subject to certain authorities that are reserved to Trinity Health. RHMs may be based on a geographical market or dedicated to a service line or business.

"Significant Finance Matters" shall refer to the following matters which pursuant to the System Authority Matrix are subject to the approval of Trinity Health: (a) capital expenditures and dispositions; (b) incurrence of additional debt; and (c) execution of contracts and leases.

"System Authority Matrix" refers to the document that sets forth an allocation of corporate governance authority that is binding on the Corporation and its Affiliates as part of the Health System, a copy of which is attached and incorporated into these Bylaws as Exhibit A, and as may be amended by Trinity Health from time to time.

"Trinity Health" means Trinity Health Corporation, an Indiana nonprofit corporation, its successors and assigns.

## Article II. PURPOSES

### Section 2.01 Purposes

The purposes of the Corporation are set forth in the Certificate of Incorporation of the Corporation.

### Section 2.02 Catholic Identity

The activities of the Corporation shall be carried out in a manner consistent with the teachings of the Roman Catholic Church and "Founding Principles of Catholic Health Ministries" or successor documents which set forth principles describing how the apostolic and charitable works of Catholic Health Ministries are to be carried out, as well as the values and principles inherent in the medical-moral teachings of the Roman Catholic Church (such as the Ethical and Religious Directives for Catholic Health Care Services as promulgated from time to time by the United States Conference of Catholic Bishops (or any successor organization), as amended from time to time).

### Section 2.03 Mission Statement

The Mission and Core Values of the Corporation shall be as adopted and approved from time to time by Catholic Health Ministries. The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation. The mission statement of the Corporation shall be as follows:

*"We serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."*

The mission statement may by action of the Corporation's Board of Directors be supplemented by reference to the purposes of the Corporation.

### Section 2.04 Alienation of Property

Under Canon Law, Catholic Health Ministries shall retain its canonical stewardship with respect to those facilities, real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to Catholic Health Ministries. No alienation, within the meaning of Canon Law, of property considered to be stable patrimony of Catholic Health Ministries shall occur without prior approval of Catholic Health Ministries.

## ARTICLE III. MEMBER

### Section 3.01 Sole Member

The sole member of the Corporation is Saint Francis Care, Inc., a Connecticut nonstock corporation, or its successors or assigns.

**Section 3.02 Member Authority**

The following actions shall be reserved exclusively to the Member of the Corporation. Subject to the reserved powers of Trinity Health, the Member may initiate and implement any proposal with respect to any of the following, or if any proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approvals and other actions shall have been taken by the Member and Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Approve the amendment or restatement of the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, and recommend the same to Trinity Health for adoption;

(b) Appoint and remove members of the Corporation's Board of Directors;

(c) Appoint and remove the President of the Corporation;

(d) Approve the strategic plan of the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption as part of the consolidated strategic plan of the Regional Health Ministry in which the Corporation participates;

(e) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of the Member, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(f) Approve the annual operating and capital budgets of the Corporation, and recommend the same to Trinity Health for adoption as part of the consolidated operating and capital budgets of the Regional Health Ministry in which the Corporation participates;

(g) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(h) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(i) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(j) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), and if required by the System Authority Matrix, recommend the same to Trinity Health for adoption and authorization;

(k) Approve any change to the structure or operations of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, and recommend the same to Trinity Health for approval; and

(l) Approve all other matters and take all other actions reserved to members of nonprofit corporations (or shareholders of for-profit-corporations, as the case may be) by the laws of the state in which the Corporation is domiciled or as reserved in the Governance Documents of the Corporation.

**Section 3.03 Reserved Powers of Trinity Health**

The following actions shall be reserved exclusively to Trinity Health. Trinity Health may initiate and implement any proposal with respect to any of the following, or if a proposal with respect to any of the following is otherwise initiated, it shall not become effective unless the requisite approval and other actions shall have been taken by Trinity Health, as required pursuant to the Corporation's Governance Documents:

(a) Adopt, amend, modify or restate the Certificate of Incorporation and Bylaws of the Corporation, in whole or in part, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(b) Approve those Significant Finance Matters which pursuant to the System Authority Matrix are subject to the authority of Trinity Health, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(c) Approve any merger, consolidation, transfer or relinquishment of membership rights, or the sale of all or substantially all of the operating assets of the Corporation (certain transactions and transfers of real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(d) Approve any dissolution, winding up or abandonment of operations, liquidation, filing of action in bankruptcy, receivership or similar action affecting the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(e) Approve any formation or dissolution of Affiliates, partnerships, cosponsorships, joint membership arrangements, and other joint ventures involving the Corporation, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(f) Approve any pledge or encumbrance of assets whether pursuant to a sale, capital lease, mortgage, disposition, hypothecation, or other transaction in excess of limits established by Trinity Health (pledges or encumbrances of certain real property and immovable goods may also be subject to the approval of Catholic Health Ministries), or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(g) Approve any change to the structure or operation of the Corporation which would affect its status as a nonprofit entity, exempt from taxation under Section 501(c) of the Internal Revenue Code, or if Trinity Health receives a recommendation as to any such action, approve such action as recommended;

(h) Appoint and remove the independent fiscal auditor of the Corporation;

(i) In recognition of the benefits accruing to the Corporation from Trinity Health, and in accordance to any other rights reserved to Trinity Health under applicable law or Governance Documents of the Corporation, Trinity Health shall have the power to transfer assets of the Corporation, or to require the Corporation to transfer assets, to Trinity Health or an entity Controlled by, Controlling or under common Control with Trinity Health, whether within or without the state of domicile of the Corporation, to the extent necessary to accomplish Trinity Health's goals and objectives. The Corporation shall not be required to violate its corporate or charitable purposes, the terms of any restricted gifts, the covenants of its debt instruments, or the law of any applicable jurisdiction as a result of any asset transfers to be made to or directed by the Member or Trinity Health pursuant to this provision; and

(j) Neither the Corporation, nor any of its Affiliates, shall transfer assets to entities other than Trinity Health without the approval of Trinity Health, except for (i) transfers previously approved by Trinity Health, either individually or as part of Trinity Health's budget process, (ii) transfers to any entity which is a direct or indirect subsidiary of Trinity Health and that is subject to the reserved powers set forth in Sections 3.02 and 3.03 of these Bylaws, or (iii) transfers in the ordinary course of business.

**Section 3.04 Meetings of the Member**

Meetings of the Member shall be held at the principal office of the Member or as otherwise provided in the bylaws of the Member at such time and date determined in accordance with the bylaws of the Member. Notice of meetings of the Member shall be given in accordance with the bylaws of the Member.

## ARTICLE IV. BOARD OF DIRECTORS

### Section 4.01 Duties and Powers

With the exception of the powers reserved to the Member, Trinity Health or Catholic Health Ministries under the Corporation's Governance Documents or applicable law, the Board of Directors shall govern, regulate and direct the affairs and business of the Corporation, carry out such policies and guidelines as adopted by the Member and Trinity Health and carry out such responsibilities as shall be delegated to it by the Member and Trinity Health, all in a manner consistent with the Mission and Core Values of the Corporation. Additional descriptions of the duties and powers of the Board of Directors are set forth in the System Authority Matrix. Among the matters under the direction of the Corporation's Board of Directors are the following actions:

(a) Elect the officers of the Corporation (except the President);

(b) Approve the Medical/Dental staff credentials for the hospital facilities owned and operated by the Corporation;

(c) Oversee the Corporation's relationship with the Medical/Dental staff as contemplated in Article V of these Bylaws;

(d) Adopt, amend, or repeal the Medical/Dental staff bylaws;

(e) Adopt and amend from time to time rules, regulations, and policies for the conduct of the operations and affairs of the Corporation;

(f) Develop and monitor the Corporation's quality improvement programs and approve quality and safety standards that shall be consistent with Trinity Health System quality and safety standards;

(g) Conduct an annual review of the Corporation's quality and safety performance; and

(h) Recommend to the Member or Trinity Health matters relating to the Corporation that require the approval or other action of the Member or Trinity Health pursuant to the Corporation's Governance Documents.

### Section 4.02 Appointments and Composition

The Member shall appoint a Board of Directors on the basis of qualifications and criteria established by the Member. Except as otherwise authorized by action of the Member, the members of the Corporation's Board of Directors shall include: (i) at least one representative of the Member, designated by the Member (who shall serve ex officio with vote) (the "Member Director"), and, unless the Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation is designated as the Member Director, the

Chief Executive Officer/Executive Vice Chief Executive Officer of the Corporation (who shall serve ex officio with vote), (ii) at least one physician, and (iii) members of the local community or members or associates of a Roman Catholic religious congregation who need not reside in the local community. Any exception to the Board composition requires the approval of the Member. The size of the Board shall be established by the Member, by policy or otherwise.

**Section 4.03 Term**

Directors shall serve a three-year term, or such shorter term as may be determined by the Member in order to achieve continuity in board composition. Ex officio members of the Board of Directors shall cease to be Directors upon the termination of their service in the office resulting in their ex officio service on the Board of Directors. Other than ex officio members, no Directors may serve for more than nine (9) consecutive years, unless appointed to complete the unexpired term of another Director, in which case a Director may serve for up to ten (10) consecutive years. Former Directors are eligible for reappointment after a one-year absence from service.

**Section 4.04 Annual Meeting of the Board of Directors**

An annual meeting of the Board of Directors shall be held at any time during the last six months of the calendar year for the purpose of the appointment of officers and the transaction of such other business as may properly come before the meeting. Notice of the annual meeting shall be given not less than ten (10) nor more than sixty (60) days before the date of the meeting. The meeting notice shall specify the date, time and place of the meeting. Presence at any such meeting shall be deemed to be waiver of notice of said meeting.

**Section 4.05 Regular Meetings and Notice**

Regular meetings of the Board of Directors shall be held as determined by the Board but no less frequently than quarterly at such time, place and date as determined from time to time by the Board of Directors. An agenda, indicating items requiring a vote of the members of the Board of Directors, together with copies of reports, statements and other supporting information shall be mailed by the Chief Executive Officer prior to meetings. No notice of regular meetings shall be required other than the resolution setting the time, place and date of the meeting.

**Section 4.06 Special Meetings and Notice**

Special meetings of the Board may be called by or at the request of the Chair, by written request of any two (2) members of the Board, or by the Member. The special meeting shall be held within five (5) days after receipt of such request. Notice of the special meeting shall be given in writing, personally, by telephone, electronic transmission or by facsimile transmission at least forty-eight (48) hours prior to the special meeting. The notice of any special meeting shall state the purpose for which it is called. No other business shall be transacted at the special meeting except for that business stated in the notice.

**Section 4.07 Waiver of Notice**

Attendance of a Director at a meeting constitutes a waiver of notice of the meeting except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Notice also may be waived in writing, either before or after the meeting.

**Section 4.08 Quorum and Valid Director Action**

At all meetings of the Board, a simple majority of the Directors then in office shall constitute a quorum for the transaction of business. The vote of a majority of the Directors present and voting at any meeting at which a quorum is present shall constitute the act of the Board, unless the vote of a larger number is specifically required by law, or by the Certificate of Incorporation, Bylaws or policies of the Corporation.

**Section 4.09 Written Consents**

Any action required or permitted to be taken by vote at any meeting of the Board or of any committee thereof may be taken without a meeting, if before or after the action, all members of the Board or committee consent in writing. The written consents shall be filed with the minutes of proceedings of the Board or committee. Such consents shall have the same effect as a vote of the Board or committee for all purposes.

**Section 4.10 Communication Equipment**

Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of teleconference, video conference or similar communications equipment by virtue of which all persons participating in the meeting may hear each other if all participants are advised of the communications equipment and the names of the participants in the conference are divulged to all participants. Participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

**Section 4.11 Resignation**

Any Director may resign by written notice to the Chair of the Board. The Chair of the Board may resign by written notice to the Corporation's President who shall promptly thereafter notify the entire Board of Directors. Resignations shall be effective upon receipt or at a subsequent time if specified in the notice of resignation.

**Section 4.12 Removal**

Any Director may be removed with or without cause at any time by the Member. Absences of a Director from three (3) consecutive regular meetings of the Board of Directors may constitute cause for removal from the Board of Directors.

### Section 4.13 Periodic Performance Review

The Board of Directors shall periodically review its own performance and issue reports to Trinity Health summarizing the results of its review.

## ARTICLE V. MEDICAL/DENTAL STAFF

### Section 5.01 Medical/Dental Staff Bylaws

The Medical/Dental staff of the hospital operated by the Corporation shall be organized pursuant to the bylaws of the Medical/Dental staff. The bylaws shall (i) describe the organization of the medical staff, (ii) describe the qualifications and criteria for Medical/Dental staff appointment and privilege determinations, (iii) state the duties and privileges of each category of the Medical/Dental staff, (iv) include procedures for recommendations by the Medical/Dental staff on the appointment of members of the Medical/Dental staff, the delineation of their staff privileges and the initiation of corrective action taken against any member, and (v) state the requirements for completion and documentation of patient histories and physical exams. The Medical/Dental staff bylaws also shall contain procedures for the resolution of disputes that may arise regarding the granting, denial or limitation of staff privileges or corrective action taken against any member of the Medical/Dental staff, including a hearing and appeal process and the circumstances in which such hearing/appeal rights will be made available. Bylaws, rules, regulations, and policies of the Medical/Dental staff may be proposed and adopted by the Medical/Dental staff of the hospital (or other health care provider that has a Medical/Dental staff), but the bylaws, rules, regulations, policies, and amendments thereto shall not become effective until approved by the Corporation's Board of Directors.

The Board of Directors shall have final responsibility for (i) appointment and reappointment of the members of the Medical/Dental staff and delineation of their staff privileges; (ii) taking such corrective action relating to Medical/Dental staff members as it deems appropriate; (iii) ratifying the selection of Medical/Dental staff officers made by the Medical/Dental staff; (iv) ratifying the selection of heads of the departments of the Medical/Dental staff; (v) reviewing and monitoring the quality improvement programs developed by the Medical/Dental staff; and (vi) determining which categories of practitioners are eligible for appointment to the Medical/Dental Staff. The Medical/Dental staff bylaws are not deemed to be a contract and are not intended to create contractual rights or responsibilities. The Board of Directors reserves the authority to take any direct action with respect to any Medical/Dental staff appointee action it deems to be in the best interests of the hospital operated by the Corporation, whether initiated by the Medical/Dental staff or not, and the decision of the Board shall be final.

### Section 5.02 Medical/Dental Staff of Operating Units

The powers described in this Article V may be delegated to the governing body of an unincorporated operating division of governance and management of the Corporation

("Operating Unit") where such Operating Unit governing body is responsible for the operation of a hospital under applicable state law or standards of accrediting agencies. Such delegation may be accomplished by resolution or by setting forth the powers and duties of such governing body in the bylaws of the Operating Unit.

## ARTICLE VI. COMMITTEES

### Section 6.01 Committees

The Executive Committee of the Board of Directors and such other committees as state law may require shall be standing committees of the Corporation. The Board of Directors may establish such additional standing or special committees from time to time as it shall deem appropriate to conduct the activities of the Corporation and shall define the powers and responsibilities of such committees. Those other committees shall serve at the pleasure of the Board. The Corporation shall not have a separate audit committee as matters related to the audit of the Corporation's finances are consolidated at the Trinity Health level. The Board shall establish the purpose, composition, term and other operating matters relative to each such other committee. Each committee shall keep minutes in some manner reasonably intended to record the business that occurred at the meeting and shall forward these minutes to the Board of Directors.

### Section 6.02 Executive Committee

There shall be an Executive Committee, consisting of the Chair of the Board, who shall serve as chair of the Executive Committee, the Chief Executive Officer, and at least two (2) other Directors selected by vote of the Board of Directors. All members of the Executive Committee must be members of the Board of Directors. The Executive Committee shall meet on the call of the Chair or President. Except as otherwise provided by resolution of the Board or as limited by law, the Executive Committee shall exercise the power and authority of the Board when necessary or advisable between meetings of the Board and shall exercise such other powers as may be assigned from time to time by the Board. The Executive Committee shall report on its actions at the next meeting of the Board and such actions shall be subject to revision and alteration of the Board; provided, however, that the rights of third parties shall not be affected by any such revision or alteration.

### Section 6.03 Service on Committees

The committees shall establish rules and regulations for meetings and shall meet at such times as are necessary, provided that a reasonable notice of all meetings shall be given to committee members. No act of a committee shall be valid unless approved by the vote or written consent of a majority of its members. Committees shall keep regular minutes of their proceedings and report the same to the Board from time to time as the Board may require. Members of the committees (except the Executive Committee) shall be appointed for one (1) year by the Chair of the Board of Directors as soon as possible after the annual meeting of the Board. Members of the committees shall serve on their respective

committees through the next annual meeting or until their successors are appointed. The Chair of the Board shall fill vacancies on committees (except the Executive Committee) and appointees shall serve through the next annual meeting. The President shall be an ex officio member of all committees, except for any committee that reviews compliance or executive compensation matters.

**Section 6.04 Quorum, Meetings, Rules and Procedures**

A quorum for any meeting of a committee shall be a simple majority of the committee members or as otherwise required by applicable law, except that any ex officio members of the committee shall not be included in calculating the quorum requirement unless they are present at the meeting, in which event they shall be included towards meeting the quorum requirement. The affirmative vote of a majority of the quorum is necessary to take action of the committee, including the affirmative vote of at least one (1) member of the Board present at the meeting of the committee in order to take any action other than recommendation by the committee to the Board or Executive Committee. Minutes of all committee meetings shall be kept and forwarded to the Board. Each committee shall adopt rules for its own governance not inconsistent with these Bylaws or the acts of the Board.

**Section 6.05 Committee Composition**

The members and all chairs of committees other than the Executive Committee shall be appointed by the Chair of the Board. The chair of each committee shall be a Director. Committees, other than the Executive Committee, may include persons other than members of the Board of Directors; provided that each standing committee shall have at least two (2) Director members in addition to the Chair and Chief Executive Officer who shall serve ex officio; and provided further, that no authority of the Board may be delegated to a committee unless the majority of the members of such committee with Board delegated authority are members of the Board of Directors and otherwise in accordance with applicable law.

## ARTICLE VII. OFFICERS

**Section 7.01 Officers**

The officers of the Corporation shall be the Chair, President, Secretary and Treasurer. Additionally, upon recommendation of the President, the Board of Directors may appoint a Vice Chair, an Assistant Secretary, an Assistant Treasurer, and such other officers of the Corporation as shall be deemed necessary and appropriate from time to time. Officers shall hold their respective offices until their successors are chosen and qualified.

**Section 7.02 Appointment and Election of Officers**

The President of the Corporation shall be appointed, evaluated, reappointed and/or removed by the Member. The President shall be Chief Executive Officer of the Corporation and any vacancy in the office of President shall be filled by the Member. The

Chair shall serve a term of one (1) year and may be elected for a total of three (3) consecutive complete one year terms. The Chair, Treasurer and Secretary of the Corporation shall be elected at the annual meeting of the Directors by the Board of Directors. The Directors and Secretary need not be members of the Board.

**Section 7.03 Vacancies**

Vacancies, occurring for any reason, shall be filled in the same manner as appointment or election and the officer so appointed or elected shall hold office until a successor is chosen and qualified.

**Section 7.04 Chair**

The Chair shall preside at the Board meetings and shall be an ex-officio voting member of all committees.

**Section 7.05 President**

The President shall have general and active management responsibility for the business of the Corporation and shall see that all orders and resolutions of the Board of Directors and the policies of the Member are carried into effect, consistent with the Mission and Core Values of the Corporation. The President shall be responsible for the appointment, evaluation, compensation and removal of the respective executive officers of those corporations of which the Corporation is the member or other controlling shareholder or owner. The President shall be a voting ex officio member of all committees and shall have the general powers and duties of supervision and management usually vested in the office of President of a corporation.

**Section 7.06 Secretary**

The Secretary of the Corporation shall issue, or cause to be issued, notices of all Board meetings, shall be responsible for the keeping and the reporting of adequate records of all transactions of the Board, and shall record the minutes of all meetings of the Board of Directors. The Secretary shall further perform such other duties incident to his or her office and as the Board of Directors may from time to time determine.

**Section 7.07 Treasurer**

The Treasurer of the Corporation shall be responsible for all funds of the Corporation, shall make reports to the Board of Directors as requested by the Board of Directors, and shall see that an accounting system is maintained in such a manner as to give a true and accurate accounting of the financial transactions of the Corporation. The Treasurer shall further perform such other duties incident to his or her office as the Board of Directors may from time to time determine. The Treasurer may delegate any of the functions, powers, duties, and responsibilities to any agent or employee of the Corporation. In the event of such

delegation, the Treasurer shall thereafter be relieved of all responsibility for the proper performance or exercise thereof.

## ARTICLE VIII. INDEMNIFICATION AND STANDARD OF CARE

### Section 8.01 Indemnification

The Corporation shall, to the maximum extent allowed by law, indemnify those persons (including religious congregations and their members or other canonical persons and their members) who

(a) are serving or have served as members, trustees, directors, sponsors, officers, employees, committee or subcommittee members, or agents of the Corporation, or

(b) are serving or have served at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with such action, suit, or proceeding.

### Section 8.02 Insurance

Except as may be limited by law, the Corporation may purchase and maintain insurance on behalf of any person (including religious congregations and their members or other canonical persons and their members) who

(a) is or was a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, or agent of the Corporation, or

(b) is or was serving at the request of the Corporation as a member, trustee, director, sponsor, officer, employee, committee or subcommittee member, agent, manager, or partner of another corporation, partnership, joint venture, trust, employee benefit plan, limited liability company or other enterprise, whether for profit or nonprofit, to protect against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not this Corporation would have power to indemnify him or her against such liability under state law.

### Section 8.03 Standard of Care

Each Director shall stand in a fiduciary relation to the Corporation and shall perform his or her duties as a Director, including his or her duties as a member of any committee of the Board upon which he or she may serve, in good faith, in a manner he or she reasonably believes to be in the best interests of the Corporation, the Member and Trinity Health, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances.

**Section 8.04 Justifiable Reliance**

In performing his or her duties, a Director (including when such Director is acting as an officer of the Corporation) shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:

(a) One or more officers or employees of the Corporation whom the Director reasonably believes to be reliable and competent in the matters presented.

(b) Counsel, public accountants or other persons on matters that the Director reasonably believes to be within the professional or expert competence of such person.

(c) A committee of the Board upon which he or she does not serve, duly designated in accordance with law, as to matters within its designated authority, which committee the Director reasonably believes to merit confidence.

A Director shall not be considered to be acting in good faith if he or she has knowledge concerning the matter in question that would cause his or her reliance to be unwarranted.

**Section 8.05 Consideration of Factors**

In discharging the duties of their respective positions, the Board of Directors, committees of the Board and individual Directors may, in considering the best interests of the Corporation, the Member and Trinity Health, consider the effects of any action upon employees, upon suppliers and customers of the Corporation and upon communities in which offices or other establishments of the Corporation, the Member and Trinity Health are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standards described herein.

**Section 8.06 Presumption**

Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a Director or any failure to take any actions shall be presumed to be in the best interests of the Corporation, the Member and Trinity Health.

**Section 8.07 Personal Liability of Directors**

No Director shall be personally liable for monetary damages for any action taken, or any failure to take any action, unless the Director has breached or failed to perform the duties of his or her office under the standards described herein, has engaged in self-dealing, or the action or inaction constitutes willful misconduct or recklessness. The provisions of this Section shall not apply to the responsibility or liability of a Director pursuant to any criminal statute or the liability of a Director for the payment of taxes pursuant to local, state or federal law.

Nothing in this Article is intended to preclude or limit the application of any other provision of law that may provide a more favorable standard or higher level of protection for the Corporation's Directors.

## ARTICLE IX. SUBSIDIARIES AND VOLUNTARY HOSPITAL SERVICE ORGANIZATIONS

### Section 9.01 Authority

In accordance with policies of Trinity Health, including without limitation those referenced in the System Authority Matrix, each organization of which the Corporation is the sole or majority member or owner shall have reserved certain powers to be exercised by this Corporation.

### Section 9.02 Voluntary Hospital Service Organizations

The Board of Directors may authorize the establishment or dissolution of voluntary service organizations, such as an auxiliary to the Corporation or any Operating Unit of the Corporation. Such organization may be a non-profit corporation or voluntary association. No service organization may be established without approval of the Board of Directors, subject to the reserved powers of the Member and Trinity Health and any guidelines or policies established by Trinity Health with respect to voluntary organizations.

## ARTICLE X. OPERATING UNITS

### Section 10.01 Authority

The Board of Directors of the Corporation may organize the operations of the Corporation into one or more other Operating Units of governance and management that shall have such powers and shall carry out such responsibilities as shall be delegated to them pursuant to the policies of the Corporation and Trinity Health in effect from time to time.

## Article XI. MISCELLANEOUS

### Section 11.01 Fiscal Year

The fiscal year of the Corporation shall end on the 30th day of September of each year and shall begin on the 1st day of October of each year.

### Section 11.02 Required Records

The officers, agents and employees of the Corporation shall maintain such books, records and accounts of the Corporation's business and affairs as may be from time to time

required by the Board of Directors, or required by the laws of the state in which the Corporation is domiciled.

**Section 11.03 Confidentiality**

Except as otherwise publicly disclosed, or in order to appropriately conduct the Corporation's business, the records and reports of the Corporation shall be held in confidence by those persons with access to them.

**Section 11.04 Conflict of Interest**

Each of the Corporation's officers and members of the Board shall at all times act in a manner that furthers the Corporation's charitable purposes and shall exercise care that he or she does not act in a manner that furthers his or her private interests to the detriment of the Corporation's community benefit purposes. The Corporation's officers and members of the Board shall fully disclose to the Corporation any potential or actual conflicts of interest, if such conflicts cannot be avoided, so that such conflicts are dealt with in the best interests of the Corporation. Conflicts of interest shall be resolved in accordance with the Corporation's conflict of interest policy. The Corporation and all its officers and members of the Board shall comply with any policies of the Corporation and Trinity Health regarding conflicts of interest, as well as the requirements of applicable state law regarding such conflicts, and shall complete any and all disclosure forms as may be deemed necessary or useful by the Corporation for identifying potential conflicts of interest.

## ARTICLE XII. AMENDMENT AND REVIEW

**Section 12.01 Amendment**

These Bylaws may be amended only in accordance with Article III of these Bylaws.

**Section 12.02Periodic Review**

These Bylaws shall be reviewed periodically by the Board of Directors and any recommended revisions shall be forwarded to the Member and Trinity Health for action.

EXHIBIT A

System Authority Matrix

# DISCLOSURE SCHEDULE

This Disclosure Schedule (this "Disclosure Schedule") is being delivered pursuant to the terms of that certain Membership Transfer Agreement (the "Agreement"), dated as of September 18, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation ("Trinity Health"), Saint Francis Care, Inc., a Connecticut nonstock corporation ("NE-RHM"), and Saint Mary's Health System, Inc. ("SMHS") and Saint Mary's Hospital, Inc. ("SMH"), both Connecticut nonstock corporations (collectively, "Saint Mary's"). The substitution of NE-RHM for the Archbishop of Hartford as the sole member of Saint Mary's and the other transactions contemplated by the Agreement are referred to collectively in this Disclosure Schedule as the "Transaction."

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to NE-RHM and Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

## DISCLOSURE SCHEDULES

Schedule 1A .....Knowledge of Saint Mary's

Schedule 1B .....Knowledge of NE-RHM

Schedule 1C .....Knowledge of Trinity Health

Schedule 2.01..... Board of Directors and Officers of SMH

Schedule 3.02.....Board of Directors and Officers of RHM

Schedule 6.04.....Conflicts/Consents

Schedule 6.05.....Organizational Chart

Schedule 6.08.....Absence of Certain Changes, Events and Conditions

Schedule 6.09(a) .....Contracts of Saint Mary's and the Saint Mary's Controlled Subsidiaries

Schedule 6.09(c) .....Material Contracts

Schedule 6.10.....Permitted Encumbrances

Schedule 6.12(a) .....Owned Real Property/Encumbrances

Schedule 6.12(b) .....Leased Real Property

Schedule 6.14(a) .....Legal Proceedings

Schedule 6.14(b) .....Governmental Orders, Judgments, Penalties, Awards

Schedule 6.15(a) .....Compliance With Laws/Permits

Schedule 6.16(a) .....Government Program Survey Reports

Schedule 6.16(b) .....Reimbursement Claims

Schedule 6.16(d) .....Accreditation Survey Report and Deficiency List

Schedule 6.19.....Breach Notifications

Schedule 6.22(a) .....Employee Benefit Plans

Schedule 6.22(c) .....Employee Pension Benefit Plans

Schedule 6.22(d) .....Multiemployer Plans

Schedule 6.22(e) .....Church Plans

Schedule 6.22(f).....Employee Welfare Benefit Plans

Schedule 6.22(g) .....Agreements with Employees, Etc.

Schedule 6.22(h) .....Prohibited Transactions

Schedule 6.22(k) .....Nonqualified Deferred Compensation Plans

Schedule 6.23.....Collective Bargaining Agreements; Threats of Strike, Slowdown, etc.

Schedule 6.24 ..... Tax Returns, Tax Payments
Schedule 6.25 ..... Insurance Policies
Schedule 7.04 ..... Conflicts/Consents
Schedule 7.08(a) ..... Compliance with Laws
Schedule 7.09(a) ..... Government Program Survey Reports
Schedule 7.09(b) ..... Reimbursement Claims
Schedule 7.12 ..... Breach Notification
Schedule 8.08(a) ..... Owned Real Property

**DISCLOSURE SCHEDULE**

This Disclosure Schedule (this **"Disclosure Schedule"**) is being delivered pursuant to the terms of that certain Transfer Agreement (the **"Agreement"**), dated as of _____, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation (**"Trinity Health"**), Saint Francis Care, Inc., a Connecticut nonstock corporation (**"NE-RHM"**), and Saint Mary's Health System, Inc. (**"SMHS"**) and Saint Mary's Hospital, Inc. (**"SMH"**), both Connecticut nonstock corporations (collectively, **"Saint Mary's"**). The substitution of **NE-RHM** for the Archbishop of Hartford as the sole member of Saint Mary's and the other transactions contemplated by the Agreement are referred to collectively in this Disclosure Schedule as the "Transaction."

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to **NE-RHM and** Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

## DISCLOSURE SCHEDULES


Schedule 1A _____ Knowledge of Saint Mary's

Schedule 1B _____ Knowledge of NE-RHM

Schedule 1C _____ Knowledge of Trinity Health

Schedule 3.02 _____ Board of Directors of NE-RHM - Saint Mary's Members

Schedule 6.04 _____ Conflicts/Consents

Schedule 6.05 _____ Organizational Chart

Schedule 6.07 _____ Undisclosed Liabilities

Schedule 6.08 _____ Absence of Certain Changes, Events, Conditions

Schedule 6.09 _____ Material Contracts

Schedule 6.09(c) _____ Material Contracts - Validity

Schedule 6.10 _____ Permitted Encumbrances

Schedule 6.11 _____ Condition and Sufficiency of the Saint Mary's Assets

Schedule 6.12(a) _____ Owned Real Property

Schedule 6.12(b) _____ Leased Real Property

Schedule 6.14(a) _____ Legal Proceedings

Schedule 6.14(b) _____ Governmental Orders

Schedule 6.15(a) _____ Compliance With Laws

Schedule 6.16(a) _____ Medicare - Plans of Correction

Schedule 6.16(b) _____ Medicare - Claims

Schedule 6.16(d) _____ Medicare - Accreditation Surveys/Deficiency List

Schedule 6.19 _____ HIPAA - Breach Notifications

Schedule 6.20 _____ Affiliate Transactions

Schedule 6.21(e) _____ Environmental

Schedule 6.22(a) _____ Employee Benefit Plans

Schedule 6.22(b) _____ Benefit Plans - Compliance

Schedule 6.22(c) _____ Employee Pension Benefit Plan Liability

Schedule 6.22(d) _____ Multiemployer Plan Liability

Schedule 6.22(e) _____ Church Plans

Schedule 6.22(f) _____ Employee Welfare Benefit Plans

Schedule 6.22(g) _____ Effect of Execution and Consummation of Agreement on Saint Mary's Benefit Plans

Schedule 6.23 _____ Employment Matters

Schedule 6.24 _____ Taxes

Schedule 6.25 _____ Insurance

Schedule 7.04 _____ Conflicts - Trinity Health and NE-RHM

Schedule 7.08(a) _____ Compliance with Laws - NE-RHM

Schedule 7.09(a) _____ Medicare - Plans of Correction - NE-RHM

Schedule 7.09(b) _____ Medicare/Medicaid - NE-RHM Claims

Schedule 7.12 _____ HIPAA - Breach Notifications - NE-RHM

Schedule 8.08(a) _____ Insured Real Property

**Schedule 1A**

**Knowledge of Saint Mary's**

1. Chad Wable, CEO
2. Ralph Becker, CFO
3. Chip Flynn, COO
4. Steve Schneider, MD, Chief Medical Officer, President of Franklin Medical Group

**Schedule 1B**

**Knowledge of NE-RHM**

1. Christopher M. Dadlez, President and CEO
2. John Rodis, Executive Vice President and COO
3. David Bittner, Senior Vice President of Finance, CFO
4. Janeanne C. Lubin-Szafranski, Vice President and General Counsel
5. Jennifer S. Schneider, Vice President of Finance

**Schedule 1C**

**Knowledge of Trinity Health**

1. James R. O'Connell, Executive Vice President
2. Paul Neumann, Executive Vice President and General Counsel
3. Benjamin Carter, Executive Vice President and CFO
4. Michael Holper, Senior Vice President

**Schedule 2.01**

**SMH Board Members**

**The initial members of the SMH Board will be identified by the Parties prior to the Closing Date**

**Schedule 3.02**

**Board of Directors of NE-RHM - Saint Mary's Members**

**To be identified by Parties prior to the Closing Date**

**Schedule 6.04**

**Conflicts/Consents**

(a) None.

(b)

OHCA CON Order, Docket No. 08-31202. Condition 2(b) to the Order provides that the Heart Center's CON authorization will become invalid and therefore null and void if, "any changes in the ownership or control of one or both of the legal entities, [Saint Mary's Hospital or the Waterbury Hospital]" occur. Saint Mary's and Waterbury Hospital are in the process of filing a CON Modification requesting that OHCA vacate Condition 2(b).

(c)(i)

(1) Waterbury Hospital pursuant to Members' Agreement among Saint Mary's Hospital, the Waterbury Hospital, and the Harold Leever Regional Cancer Center, Inc., dated May 17, 1999, the Members' Agreement among St. Mary's Hospital, the Waterbury Hospital, and Waterbury Area Heart Center, Inc., dated December 22, 2003, and the bylaws of both Harold Leever and the Heart Center.

(2) Operating Agreement of Naugatuck Valley MRI, LLC, dated January 26, 2015

(3) Connecticut Department of Social Services Health Care Financing - Provider Enrollment Agreement, dated 3/12/09, between CT DSS and Saint Mary's Hospital. Re-enrollment requires notification

(4) Craneware License and Service Agreement, dated 4/29/13, between Craneware plc and Saint Mary's Hospital. Assignment, which includes change of ownership, requires consent.

(5) McKesson Premier Member Letter of Participation, dated 12/16/13, between McKesson and Saint Mary's Health System, Inc. Notice required on change of ownership.

(6) The following consents, approvals, Permits, Governmental Orders, declaration and filings with, or notices to the following Governmental Authorities may be required by or with respect to Saint Mary's Hospital or the Saint Mary's Controlled Subsidiaries in connection with the execution and delivery of the Agreement and the other Transaction Documents and the consummation of the transaction contemplated hereby and thereby:

a. Roman Catholic Archdiocese of Hartford
b. Holy See, Roman Catholic Church
c. State of Connecticut Office of Healthcare Access
d. Office of the Attorney General of the State of Connecticut
e. Federal Trade Commission

(7) Consent may be required with respect to Diagnostic Imaging of Southbury, LLC

(c)(ii) None.

(c)(iii) None.

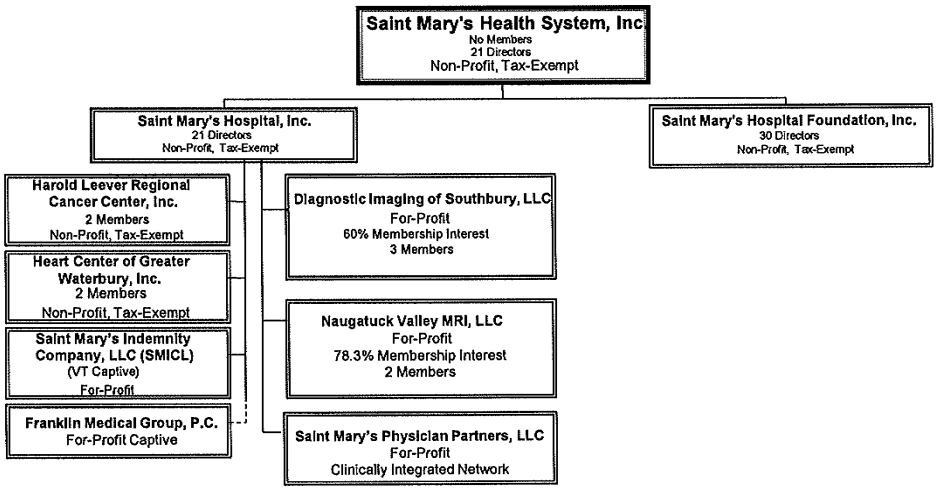
(c)(iv) None.

(c)(v)

1. Master Service Agreement, dated 1/5/09, between Connecticut Children's Medical Center and Saint Mary's Hospital, Inc.

# Schedule 6.05

## Organizational Chart




August 2015

**Schedule 6.07**

**Undisclosed Liabilities**

1. Amended and Restated Commercial Revolving Note, dated August 16, 2010, in favor of Webster Bank, National Association for the principal sum of $5,000,000

2. Amended and Restated Commercial Loan Agreement, dated March 11, 2015 by and between Webster Bank, National Association and Saint Mary's Hospital, Inc.

3. Asset Pledge, Security and Control Agreement dated August 16, 2010 by and among Webster Bank, National Association and Saint Mary's Hospital, Inc.

4. Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

   Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

**Schedule 6.08**

**Absence of Certain Changes, Events, Conditions**

6.08(a):

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

6.08(b):

Saint Mary's is in the process of converting Franklin Medical Group to a Medical Foundation.

6.08(c): None

6.08(d): None

6.08(e): None

6.08(f): None

6.08(g): None

6.08(h): None

6.08(i): None

6.08(j):

An electrical transformer failed in July 2015. Replacement of the transformer itself and associated labor are expected to be greater than $100,000. Incident has not been submitted to

insurance. Awaiting final invoices from contractor.

6.08(k):

The receivable for $315k as of June 30, 2015 for CVS retail pharmacy will be written off by end of year. The retail pharmacy program started in April FY15. The program is being discontinued. Approximately $165k was accrued for expenses associated with these revenues. Those will also be released to income. The net impact to the income statement will be approximately $150k.

SMH capitalized $904k worth of fixed asset additions in the month of July. Cath Lab equipment ($190k) and build out of West Main Urgent Care ($151k) were included.

6.08(l): None

6.08(m): None

6.08(n): None

6.08(o): None

6.08(p): None

6.08(q): None

6.08(r): None

**Schedule 6.09**

**Material Contracts**

**(i) Each Contract involving aggregate consideration in excess of $100,000**

See attached.

**(ii) All Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000**

1. Asset Purchase Agreement by and among Saint Mary's Hospital, Inc. and Joseph Bowen, M.D., dated June 1, 2014

2. Asset Purchase Agreement by and among Franklin Medical Group, P.C. and Digestive Disease Center of CT, LLC, dated May 23, 2014

**(iii) All Contracts with any Governmental Authority**

1. Student Educational Affiliation Agreement between Waterbury Department of Education and Saint Mary's Hospital, July 27, 2007

2. Provider Enrollment Agreement between Connecticut Department of Social Services and Saint Mary's Hospital, dated March 3, 2009

3. Board of Trustees of Community-Technical Colleges on behalf of Northwestern Connecticut Community College, dated January 3, 2011

4. Student Educational Affiliation Agreement between University of Connecticut, School of Social Work and Saint Mary's Hospital, dated January 17, 2011

5. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Franklin Medical Group, dated October 14, 2011

6. Educational Agreement between the University of Connecticut School of Medicine and Saint Mary's Hospital, dated December 20, 2011

7. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated November 7, 2012

8. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Saint Mary's Hospital, dated November 21, 2012

9. In-State Student Affiliation Agreement between University of Connecticut, Department of Allied Health Sciences and Saint Mary's Hospital, dated January 1, 2013

10. In-State Student Affiliation Agreement between University of Connecticut School of Nursing and Saint Mary's Hospital, dated January 2, 2013

11. Child Day Care License between State of Connecticut Department of Public Health and Saint

Mary's Hospital, dated March 20, 2013

12. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated March 22, 2013

13. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated May 5, 2013

14. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated June 19, 2013

15. Purchase of Service Contract between Department of Public Health and Saint Mary's Hospital, dated July 1, 2013

16. Student Education Affiliation Agreement between Western Connecticut State University and Saint Mary's Hospital, dated September 7, 2013

17. Contract between Board of Regents for Higher Education on behalf of Gateway Community College and Saint Mary's Hospital, dated October 22, 2013

18. Student Education Affiliation Agreement between Central Connecticut State University and Saint Mary's Hospital, dated October 28, 2013

19. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, dated March 4, 2014

20. Personal Service Agreement between State of Connecticut Office of the State Comptroller and Saint Mary's Hospital, dated February 6, 2015

21. Contract between Board of Regents for Higher Education on behalf of Naugatuck Valley Community College and Saint Mary's Hospital, Inc., dated February 20, 2015

22. In-State Student Educational Training Affiliation Agreement between University of Connecticut, Department of Kinesiology and Saint Mary's Hospital, dated May 28, 2015

23. Agreement between City of Waterbury and Saint Mary's Hospital Child Development Center (pending City signature)

**(iv) Any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement**

1. Members' Agreement among Saint Mary's Hospital, the Waterbury Hospital, and the Harold Leever Regional Cancer Center, Inc., dated May 17, 1999.

2. Members' Agreement among St. Mary's Hospital, the Waterbury Hospital, and Waterbury Area Heart Center, Inc., dated December 22, 2003

3. Operating Agreement of Southbury Diagnostic Imaging Center, LLC, dated October 7, 1998

4. Operating Agreement of Naugatuck Valley MRI, LLC, dated January 26, 2015

5. Affiliation Agreement among The Waterbury Hospital and St. Mary's Hospital, dated December 22, 2003

**(v) All Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand**

1. Cardiac Anesthesia Services Agreement between the Heart Center of Greater Waterbury, Inc. and Saint Mary's Hospital Inc., dated October 2007

2. Operating Agreement of Saint Mary's Physician Partners, LLC, dated June 27, 2014

3. Operating Agreement of Saint Mary's Indemnity Company, LLC, dated July 1, 2009

4. Services Agreement by and between the Harold Leever Regional Cancer Center, Inc., and Saint Mary's Hospital, dated October 9, 2002

5. Emergency Department Services Agreement by and between Saint Mary's Hospital and Franklin Medical Group, P.C., dated May 1, 2003

6. Management Services Agreement among Community Radiology Network, LLC, and Diagnostic Imaging of Southbury, LLC, dated January 1, 2003

7. Management Services Agreement among Community Radiology Network, LLC, and Diagnostic Imaging of Southbury, LLC, dated January 1, 2003

8. Cardiology Services Agreement by and between Waterbury Heart Center, Inc., St. Mary's Hospital, and Waterbury Hospital, and Cardiology Associates of Waterbury, P.C., dated November 1, 2004

**(vi) All collective bargaining agreements or Contracts with any union, works council, or labor organization to which SMH or a SMH Controlled Subsidiary is a party**

None.

**(vii) All Contracts relating to indebtedness having an outstanding principal amount of $100,000**

1. Amended and Restated Commercial Revolving Note, dated August 16, 2010, in favor of Webster Bank, National Association for the principal sum of $5,000,000

2. Amended and Restated Commercial Loan Agreement, dated March 11, 2015 by and between Webster Bank, National Association and Saint Mary's Hospital, Inc.

3. Asset Pledge, Security and Control Agreement dated August 16, 2010 by and among Webster Bank, National Association and Saint Mary's Hospital, Inc.

4. Master Lease Agreement by and between Saint Mary's Hospital and De Lage Landen Financial Services, Inc., dated December 28, 2009, as amended

# SAINT MARY'S HOSPITAL CONTRACTS

## MASTER COMMERCIAL CONTRACTS

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.1002C | Saint Mary's Hospital | Geonetric Technology |
| 1001.1007E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1008E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1009E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1012C | Saint Mary's Hospital | McKesson Corporation |
| 1001.1016C | Saint Mary's Hospital | Medtronic, Inc. |
| 1001.1017C | Saint Mary's Hospital | Medtronic, Inc. |
| 1001.1019C | Saint Mary's Hospital | Quinnipiac University |
| 1001.1024E | Saint Mary's Hospital | Nuance Powerscribe |
| 1001.1025E | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.1050C | Saint Mary's Hospital | RelayHealth |
| 1001.1053C | Saint Mary's Hospital | RelayHealth |
| 1001.1054C | Saint Mary's Hospital | Connecticut Hospital Association |
| 1001.1060C | Saint Mary's Hospital | Roche Diagnostics Corporation |
| 1001.1063E | Saint Mary's Hospital | Nuance Communications, Inc. |
| 1001.1064E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1065C | Saint Mary's Hospital | McKesson Technologies, Inc. |
| 1001.1071C | Saint Mary's Hospital | Leidos Health LLC |
| 1001.1083C | Saint Mary's Hospital | Medtronic USA, Inc. |
| 1001.1085C | Saint Mary's Hospital | JVK Operations |
| 1001.1092C | Saint Mary's Hospital | WB Mason |
| 1001.1099C | Saint Mary's Physician Partners, LLC | Naugatuck Valley Women's Health Specialists, PC |
| 1001.1100E | Saint Mary's Hospital | Wellsoft Corporation |
| 1001.1119C | Saint Mary's Hospital | Healthstream, Inc. |
| 1001.1120C | Saint Mary's Hospital | Medtronic USA, Inc. |
| 1001.1121C | Saint Mary's Hospital | Allscripts Healthcare, LLC |
| 1001.1160C | Saint Mary's Hospital | Cardinal Health 200, LLC |
| 1001.1161C | Saint Mary's Hospital | Spirit of Women Health Network |
| 1001.1165C | Saint Mary's Hospital | Kronos |
| 1001.1168C | Saint Mary's Hospital | Siemens Healthcare Diagnostics Inc. |
| 1001.1171C | Saint Mary's Hospital | Grainger Industrial Supply |
| 1001.1173C | Saint Mary's Hospital | Anthelio Healthcare Solutions, Inc. |
| 1001.1177C | Saint Mary's Hospital | Truven Health |
| 1001.1178C | Saint Mary's Hospital | Spendadvisor |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.1185C | Saint Mary's Hospital | Universal Background Screening |
| 1001.1187C | Saint Mary's Hospital | Siemens Medical Solutions USA, Inc. |
| 1001.1188C | Saint Mary's Hospital | Siemens Medical Solutions USA, Inc. |
| 1001.1189C | Saint Mary's Hospital | Intuitive Surgical, Inc. |
| 1001.1191C | Saint Mary's Hospital | Beckman Coulter |
| 1001.1193C | Saint Mary's Hospital | Draeger Medical, Inc. |
| 1001.1194C | Saint Mary's Hospital | Carl Zeiss Incorporated |
| 1001.1204C | Saint Mary's Hospital | Cross Country Staffing |
| 1001.1221C | Saint Mary's Hospital | Bard Peripheral Vascular, Inc. |
| 1001.1225C | Saint Mary's Hospital | NVMRI |
| 1001.1226C | Saint Mary's Hospital | Edwards Lifesciences LLC |
| 1001.1231C | Saint Mary's Hospital | Siemens Medical Solutions USA, Inc. |
| 1001.1237C | Saint Mary's Hospital | Covidien Sales, LLC |
| 1001.1248C | Saint Mary's Hospital | McKesson Technologies, Inc. |
| 1001.1250C | Saint Mary's Hospital | St. Jude Medical |
| 1001.1274C | Saint Mary's Hospital | PMA Management Corp. of New England |
| 1001.1275C | Saint Mary's Hospital | Neuro Enterprises, LLC |
| 1001.1286C | Saint Mary's Hospital | Baxter Healthcare Corporation |
| 1001.1294C | Saint Mary's Hospital | Covidien |
| 1001.190C | Saint Mary's Hospital | St Jude Medical US Division |
| 1001.204E | Saint Mary's Hospital | Stericycle, Inc. |
| 1001.210C | Saint Mary's Hospital | Craneware, Inc. |
| 1001.216C | Saint Mary's Hospital | University of Connecticut School of Medicine |
| 1001.219C | Saint Mary's Hospital | Cardinal Health 200, LLC |
| 1001.228C | Saint Mary's Hospital | Naugatuck Valley Lawn Maintenance, Inc. |
| 1001.235E | Saint Mary's Hospital | School Readiness Grant Program |
| 1001.266E | Saint Mary's Hospital | Connecticut Children's Medical Center |
| 1001.287C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.304E | Saint Mary's Hospital | Stryker |
| 1001.332C | Saint Mary's Hospital | Heart Center of Greater Waterbury, Inc. |
| 1001.354E | Saint Mary's Hospital | Sodexho Operations, LLC |
| 1001.367E | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.393C | Saint Mary's Hospital | 3M Health Care Service Center |
| 1001.411C | Saint Mary's Hospital | Cardinal Health 200, LLC |
| 1001.418E | Saint Mary's Hospital | TPC Associates, Inc. |
| 1001.420C | Saint Mary's Hospital | Western Connecticut State University |
| 1001.427C | Saint Mary's Hospital | Sodexho Operations, LLC |
| 1001.430C | Saint Mary's Hospital | Yale University School of Medicine |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.433C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.444C | Saint Mary's Hospital | Northwestern Connecticut Community College |
| 1001.44C | Saint Mary's Hospital | Toshiba America Medical Systems Inc. |
| 1001.44C | Saint Mary's Hospital | Toshiba America Medical Systems Inc. |
| 1001.468C | Saint Mary's Hospital | University of Connecticut, Department of Allied Health Sciences |
| 1001.469C | Saint Mary's Hospital | University of Connecticut School of Nursing |
| 1001.474C | Saint Mary's Hospital | Haemonetics Corporation |
| 1001.47C | Saint Mary's Hospital | Siemens Medical Solutions USA, Inc. |
| 1001.482C | Saint Mary's Hospital | Department of Public Health |
| 1001.489C | Saint Mary's Hospital | Gateway Community College |
| 1001.490C | Saint Mary's Hospital & Health System | Santa Buckley Energy, Inc. |
| 1001.495E | Saint Mary's Hospital | GE Healthcare |
| 1001.519C | Saint Mary's Hospital | University of Connecticut School of Social Work |
| 1001.521C | Saint Mary's Hospital | Department of Social Services |
| 1001.525C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.527E | Saint Mary's Hospital | Connecticut Light and Power Company |
| 1001.541C | Saint Mary's Hospital | Waterbury Department of Education |
| 1001.545C | Saint Mary's Hospital | Healthstream, Inc. |
| 1001.54C | Saint Mary's Hospital | 3M Health Care Service Center |
| 1001.590C | Saint Mary's Hospital | bioMerieux, Inc. |
| 1001.592C | Saint Mary's Hospital | American National Red Cross |
| 1001.603C | Saint Mary's Hospital | Unitex Textile Rental Services |
| 1001.608C | Saint Mary's Hospital | City-Wide Delivery Service, Inc. |
| 1001.632C | Saint Mary's Hospital | McKesson Health Solutions, LLC |
| 1001.633E | Saint Mary's Hospital | Otis Elevator Company |
| 1001.653C | Saint Mary's Hospital | Siemens Industry, Inc. |
| 1001.668C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.676E | Saint Mary's Hospital | SkillSurvey |
| 1001.679C | Saint Mary's Hospital | 3M Health Care Service Center |
| 1001.681C | Heart Center of Greater Waterbury | University of Connecticut Health Center Department of Finance |
| 1001.682C | Saint Mary's Hospital | Med3000, Inc. |
| 1001.688C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.691C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.694C | Saint Mary's Hospital | Healthstream, Inc. |
| 1001.749C | Saint Mary's Hospital | Connecticut Light and Power Company |
| 1001.750C | Saint Mary's Hospital | Connecticut Light and Power Company |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.768C | Saint Mary's Health System | Axiom Group, LLC |
| 1001.783C | Saint Mary's Hospital | Best Practices, Inc. |
| 1001.785C | Saint Mary's Hospital | MedAssets Net Revenue Systems, LLC |
| 1001.786C | Saint Mary's Hospital | Precyse Solutions, LLC |
| 1001.787E | Saint Mary's Hospital | GE Medical Systems |
| 1001.788C | Saint Mary's Hospital | Financial Health Strategies, Inc. |
| 1001.811C | Saint Mary's Hospital | Department of Public Health |
| 1001.814C | Saint Mary's Hospital | Executive Health Resources, Inc. (E.H.R.) |
| 1001.820E | Saint Mary's Hospital | Dell |
| 1001.8221C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.822C | Saint Mary's Hospital | Healthstream, Inc. |
| 1001.825E | Saint Mary's Hospital | Diagnostic Equipment Service Corporation (DESCO) |
| 1001.829C | Saint Mary's Hospital | Precyse Solutions, LLC |
| 1001.840C | Saint Mary's Hospital | University of Connecticut School of Allied Health |
| 1001.852C | Saint Mary's Hospital | Bay State Anesthesia |
| 1001.853C | Saint Mary's Hospital | Department of Public Health |
| 1001.858C | Saint Mary's Hospital | Anthelio Healthcare Solutions, Inc. |
| 1001.860C | Saint Mary's Hospital | Syntrac Cardinal Health |
| 1001.861C | Saint Mary's Hospital | Sunquest Information Systems, Inc. |
| 1001.866C | Saint Mary's Health System | VPNE Parking Solutions, LLC |
| 1001.882C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.883C | Saint Mary's Hospital | Siemens Medical Solutions USA, Inc. |
| 1001.884C | Saint Mary's Hospital | Olympus America, Inc. |
| 1001.886C | Saint Mary's Hospital | Telephone Nurse Triage - Kanagaratnam Jegathesan, MD |
| 1001.890E | Saint Mary's Hospital | Corepoint |
| 1001.891C | Saint Mary's Hospital | Advantage RN |
| 1001.944C | Saint Mary's Hospital | RelayHealth |
| 1001.950C | Saint Mary's Hospital | Xtend Healthcare, LLC |
| 1001.962C | Saint Mary's Hospital | Precyse Solutions, LLC |
| 1001.979C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.997C | Saint Mary's Health System, Inc. | McKesson Corporation |
| 1002.1048C | Franklin Medical Group, P.C. | Nuance Communications, Inc. |
| 1002.1090C | Franklin Medical Group, P.C. | Digestive Disease Center of CT, LLC |
| 1002.244C | Franklin Medical Group, P.C. | Naugatuck Valley OB-GYN Associates, PC |
| 1002.448C | Franklin Medical Group, P.C. | Department of Public Health |
| 1002.530C | Franklin Medical Group, P.C. | Napiello, Virginia APRN |
| 1002.572E | Franklin Medical Group, P.C. | Microsoft Licensing, GP |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1002.888E | Franklin Medical Group, P.C. | Phoenix Internal Medicine Associates, LLC |
| 1002.958C | Franklin Medical Group, P.C. | VENDOR INCORRECTLY LABELED ON LIST AS: University of Connecticut Health Center Department of Finance. CORRECT VENDOR is Night Nurse, Inc. |
| 1002.959C | Franklin Medical Group, P.C. | Thames Records Management |
| 1002.967C | Franklin Medical Group, P.C. | City-Wide Delivery Service, Inc. |
| 1002.974C | Franklin Medical Group, P.C. | Intuitive Surgical, Inc. |
| 1010.946C | Saint Mary's Hospital | Healthstream, Inc. |
| 1010.966C | Saint Mary's Hospital | Healogics Wound Care & Hyperbaric Services, Inc. |
| 1010.968C | Saint Mary's Hospital | Commerce Bank |
| 1010.978C | Saint Mary's Hospital | Central Connecticut State University |
| 1010.984E | Saint Mary's Hospital | Alliance Healthcare Services |
| 1010.985C | Saint Mary's Hospital | Jackson & Coker Permanent, LLC |

## NON-PROVIDER LEASES

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 2005.445C | Saint Mary's Hospital, Inc. | Union Square Southbury, LLC (Landlord) |
| 2005.445C | Saint Mary's Hospital, Inc. | Associated Physicians of Southbury, P.C. (Subtenant) |
| 2005.762C | Saint Mary's Hospital, Inc. | 146 Highland Associates, LLC (Landlord) |
| 2005.934E | Saint Mary's Hospital, Inc. | 1981 East Main Street, LLC (Landlord) |
| 2005.934E | Saint Mary's Hospital, Inc. (Sublandlord) | Inwelligent Healthcare, Inc. (Subtenant) |
| 2007.104C | Saint Mary's Hospital, Inc. | Scovill Commons Partners, LLC (Landlord) |
| 2007.1186E | Saint Mary's Hospital, Inc. | Subway Real Estate Corp. (Tenant) |
| 2007.1227C | Saint Mary's Hospital, Inc. | Northwest CT Public Safety Communications Center Inc. (Tenant) |
| 2007.245C | Saint Mary's Hospital Corporation | Spectrum Square, LLC (Landlord) |
| 2007.273E | Saint Mary's Hospital, Inc. | Fraydun Enterprises, LLC (Landlord) |
| 2007.285E | Saint Mary's Hospital, Inc. | Fraydun Enterprises, LLC (Landlord) |
| 2007.330E | Saint Mary's Hospital, Inc. | 500 Chase Parkway Condominium Association, Inc. (Landlord) |
| 2007.345C | Saint Mary's Hospital, Inc. | Paolo Mappelli, M.D. (Landlord) |
| 2007.509E | Saint Mary's Hospital Corporation | Scovill Commons Partners, LLC (Landlord) |
| 2007.760C | Saint Mary's Hospital | JPMCC 2003-ML1 Naugatuck Retail, LLC (Landlord) |
| 2007.761C | Saint Mary's Hospital | Park West, LLC (Landlord) |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 2007.765E APPRAISAL/OPINION - NOT REVIEWED | N/A | N/A |
| 2013.1129C | Franklin Medical Group, P.C. | 1177, LLC (Landlord) |

## PROVIDER CONTRACTS

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.1072C | Saint Mary's Hospital | Singanamala, Santhi MD |
| 1001.1082C | Saint Mary's Hospital | Waterbury Pulmonary Associates, LLC |
| 1001.1105C | Saint Mary's Hospital | Brittny Williams Howell, MD |
| 1001.110C | Saint Mary's Hospital | Martinucci, Erica MD |
| 1001.1176C | Saint Mary's Physician Partners, LLC | |
| 1001.1216C | Saint Mary's Hospital | Connecticut Children's Specialty Group, Inc. |
| 1001.1298C | Saint Mary's Hospital | Connecticut Children's Specialty Group, Inc. |
| 1001.323E | Saint Mary's Hospital | Connecticut Children's Medical Center |
| 1001.342C | Saint Mary's Hospital | Consultants In Pathology, PC |
| 1001.37C | Saint Mary's Hospital | Rho, Mira MD |
| 1001.39C | Saint Mary's Hospital | Roer, David MD |
| 1001.407C | Saint Mary's Hospital | Neurosurgery Orthopaedics & Spine Specialists PC |
| 1001.783E | Saint Mary's Hospital | EmCare, Inc. AND EmCare, Inc. |
| 1001.480C | Saint Mary's Hospital | Milford Anesthesia Associates, LLC |
| 1001.543E | Saint Mary's Hospital | Koteles, Alicia MD |
| 1001.547C | Saint Mary's Hospital | Raissi, Sina MD |
| 1001.570C | Saint Mary's Hospital (Naugatuck Valley Surgical Center Limited Partnership) | SurgiCenter Anesthesiologists, PC |
| 1001.580C | Saint Mary's Hospital | Mayo Medical Laboratories |
| 1001.593C | Saint Mary's Hospital | Zarif, Abdul MD |
| 1001.68C | Saint Mary's Hospital | Zarif, Abdulmasih MD |
| 1001.764C | Saint Mary's Hospital | Naugatuck Valley Women's Health Specialists, PC |
| 1001.988E | Saint Mary's Hospital | Wellmore Behavioral Health |
| 1002.1020C | Franklin Medical Group, P.C. | Monzurul Chowdhury, MD |
| 1002.1022C | Franklin Medical Group, P.C. | Farah Chinwalla, DO |
| 1002.1031C | Franklin Medical Group, P.C. | Bechoi Saleib, MD |
| 1002.1037C | Franklin Medical Group, P.C. | Anna Freitag, MD |
| 1002.1041C | Franklin Medical Group, P.C. | Lakshmi Polisetty, MD |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1002.1051C | Franklin Medical Group, P.C. | Frank Longo, MD |
| 1002.1067C | Franklin Medical Group, P.C. | Ken Matsuo |
| 1002.1069C | Franklin Medical Group, P.C. | Joseph Bowen, MD |
| 1002.1101C | Franklin Medical Group, P.C. | Marano, Albert |
| 1002.1102C | Franklin Medical Group, P.C. | Lyall, Bhupinder |
| 1002.1103C | Franklin Medical Group, P.C. | Feinberg, Michael |
| 1002.1104C | Franklin Medical Group, P.C. | Kraus, Mark, MD |
| 1002.1107C | Franklin Medical Group, P.C. | Anupama Paranandi, MD Infectious Disease |
| 1002.1109C | Franklin Medical Group, P.C. | Sallie Carrington, DO |
| 1002.1110C | Franklin Medical Group, P.C. | Preissler, MD Paul |
| 1002.1112C | Franklin Medical Group, P.C. | Garsten, MD Joel |
| 1002.1113C | Franklin Medical Group, P.C. | Burlison, MD Kathleen |
| 1002.1117C | Franklin Medical Group, P.C. | Cohen, Matthew, MD |
| 1002.113C | Franklin Medical Group, P.C. | Palesty, J Alexander MD |
| 1002.116C | Franklin Medical Group, P.C. | Wetmore, Robert S MD, PC |
| 1002.117C | Franklin Medical Group, P.C. | Sieling, Beth Ann MD |
| 1002.118C | Franklin Medical Group, P.C. | Sookhan, Nicole MD |
| 1002.11C | Franklin Medical Group, P.C. | Rosenhein, Brian DO |
| 1002.1208C | Franklin Medical Group, P.C. | Giacomazzi, Peter, MD |
| 1002.120C | Franklin Medical Group, P.C. | Galal, Magdy MD |
| 1002.1238C | Franklin Medical Group, P.C. | Shetty, MD Shohan |
| 1002.1240C | Franklin Medical Group, P.C. | Albin, MD Dmitry |
| 1002.1242C | Franklin Medical Group, P.C. | Neamtu, MD Andreea |
| 1002.1268C | Franklin Medical Group, P.C. | Gork MD, Ahmet |
| 1002.1269C | Franklin Medical Group, P.C. | Khan MD, Tasneem |
| 1002.1270C | Franklin Medical Group, P.C. | Salerno MD, John |
| 1002.1271C | Franklin Medical Group, P.C. | Polokoff MD, Ellen |
| 1002.1272C | Franklin Medical Group, P.C. | Leal MD, Daniel |
| 1002.1277C | Franklin Medical Group, P.C. | Medrano MD, Consuelito |
| 1002.1278C | Franklin Medical Group, P.C. | Esemuede MD, Iyare |
| 1002.1281C | Franklin Medical Group, P.C. | Thiruvengadam MD, Sudha |
| 1002.12C | Franklin Medical Group, P.C. | Sheikh, Abdul Majeed MD |
| 1002.1300C | Franklin Medical Group, P.C. | Carolyn O'Connor, MD |
| 1002.1303C | Franklin Medical Group, P.C. | Greco, Thomas MD |
| 1002.1304C | Franklin Medical Group, P.C. | Ann Marie Conti-Kelly, MD |
| 1002.15C | Franklin Medical Group, P.C. | Te, Victorio Go MD |
| 1002.18E | Franklin Medical Group, P.C. | Simms, Michael F MD |
| 1002.20C | Franklin Medical Group, P.C. | Imam, Azhar MD |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1002.22C | Franklin Medical Group, P.C. | Nawaz, Shah MD |
| 1002.23C | Franklin Medical Group, P.C. | Alston, Shawnette MD |
| 1002.25C | Franklin Medical Group, P.C. | Beri, Rohit MD |
| 1002.26C | Franklin Medical Group, P.C. | Bogursky, Sondra MD |
| 1002.299C | Franklin Medical Group, P.C. | Anthony, J Robert MD |
| 1002.29C | Franklin Medical Group, P.C. | Colodner, Gregory MD |
| 1002.34C | Franklin Medical Group, P.C. | Newell, Rebecca O MD |
| 1002.36C | Franklin Medical Group, P.C. | Ouellette, Jason MD |
| 1002.379C | Franklin Medical Group, P.C. | Chere, Mitch MD |
| 1002.3C | Franklin Medical Group, P.C. | Ramos, Rey MD |
| 1002.41C | Franklin Medical Group, P.C. | Talwalkar, Jaideep MD |
| 1002.42C | Franklin Medical Group, P.C. | Vaezy, Ali MD |
| 1002.432C | Franklin Medical Group, P.C. | Ndiaye, Mouhamed A MD |
| 1002.457C | Franklin Medical Group, P.C. | Gega, Arjet MD |
| 1002.486C | Franklin Medical Group, P.C. | Chien, Peter MD |
| 1002.493C | Franklin Medical Group, P.C. | Kelly, Paul MD |
| 1002.501C | Franklin Medical Group, P.C. | Zhang, He MD |
| 1002.503C | Franklin Medical Group, P.C. | Baba, Carolina Borz MD |
| 1002.508C | Franklin Medical Group, P.C. | Rubenstein, Stephen MD |
| 1002.513C | Franklin Medical Group, P.C. | Rovetto, Allyson MD |
| 1002.515C | Franklin Medical Group, P.C. | Brenes, Laura C MD |
| 1002.516C | Franklin Medical Group, P.C. | Zlotoff, Ronald A MD |
| 1002.517C | Franklin Medical Group, P.C. | Singanamala, Swathi MD |
| 1002.528C | Franklin Medical Group, P.C. | D'Souza, Bernard MD |
| 1002.548E | Franklin Medical Group, P.C. | University of Connecticut Health Center |
| 1002.55C | Franklin Medical Group, P.C. | Almeida, Carlos MD |
| 1002.569C | Franklin Medical Group, P.C. | Richi, Maysoun MD |
| 1002.56C | Franklin Medical Group, P.C. | Alvarez, Alexander J MD |
| 1002.58C | Franklin Medical Group, P.C. | Testa, John MD |
| 1002.59C | Franklin Medical Group, P.C. | Uberti, James G MD |
| 1002.614C | Franklin Medical Group, P.C. | Richi, Aziz MD |
| 1002.617C | Franklin Medical Group, P.C. | Toon, Claire DDS |
| 1002.655C | Franklin Medical Group, P.C. | Quinn, Edmund |
| 1002.685C | Franklin Medical Group, P.C. | Karen Kennedy |
| 1002.69C | Franklin Medical Group, P.C. | Cardiology Associates of Waterbury, PC |
| 1002.756C | Franklin Medical Group, P.C. | Zefirova, Julia MD |
| 1002.758C | Franklin Medical Group, P.C. | Cumberland, Melisha MD |
| 1002.763C | Franklin Medical Group, P.C. | Sanders, Tiffany MD |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1002.817C | Franklin Medical Group, P.C. | Mario Perez |
| 1002.827E | Franklin Medical Group, P.C. | Seli, Meltem MD |
| 1002.848C | Franklin Medical Group, P.C. | Albajrami, Oltjon MD |
| 1002.879C | Franklin Medical Group, P.C. | Ranjan, Saurabh MD |
| 1002.887C | Franklin Medical Group, P.C. | El-Hennawy, Magdy Sayed MD |
| 1002.8C | Franklin Medical Group, P.C. | Hamill, Chalmers M MD |
| 1002.915C | Franklin Medical Group, P.C. | Philip R. Corvo, MD |
| 1002.93C | Franklin Medical Group, P.C. | Naugatuck Valley OBGYN PC |
| 1002.943C | Franklin Medical Group, P.C. | Maria Dawe, MD |
| 1002.961C | Franklin Medical Group, P.C. | Macaron, Shady Hafez MD |
| 1002.972C | Franklin Medical Group, P.C. | Naugatuck Valley Women's Health Specialists, PC |
| 1002.987C | Franklin Medical Group, P.C. | Jennyffer Peralta, MD |
| 1002.993C | Franklin Medical Group, P.C. | Aditi Mukherji, MD |
| 1002.994C | Franklin Medical Group, P.C. | Richard Putnam, DMD |
| 1002.995C | Franklin Medical Group, P.C. | Rebecca Scandrett, MD |
| 1002.244C | Franklin Medical Group, P.C. | Naugatuck Valley OB-GYN Associates, PC |
| 1001.266E | Saint Mary's Hospital | Connecticut Children's Medical Center |

## PROVIDER LEASES

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 2005.364C | Saint Mary's Hospital | Saint Mary's Hospital |
| 2007.1285C | Saint Mary's Hospital | LJL Properties, LLC |
| 2007.296C | Saint Mary's Hospital | West Main Medical, LLC, a Connecticut limited liability company, as Landlord |
| 2008.534C | Primary Care Partners, P.C. | Greater Waterbury Primary Care Associates, P.C., as Tenant |

**Schedule 6.09(c)**

**Material Contracts - Validity**

To the knowledge of Saint Mary's, each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect;

To the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and

No event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder.

**Schedule 6.10**

**Permitted Encumbrances**

See attached lien report, dated September 14, 2015, prepared by CT Lien Solutions for all entities in Saint Mary's Health System

Blanket liens in favor of the master trustee (#0001772303) and in favor of Baytree National Bank & Trust Company (#0002913889) will be released prior to closing

**Schedule 6.11**

**Condition and Sufficiency of the Saint Mary's Assets**

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

**Schedule 6.12(a)**

**Owned Real Property**

1. **Parcel One**

That certain piece or parcel of land situated on the southerly side of Scovill Street, the westerly side of Franklin Street, the northerly side of Union Street and the easterly side of South Elm Street in the City of Waterbury, Conn. bounded and described as follows:

Beginning at an iron pin marking the intersection of the southerly line of Scovill Street with the easterly line of South Elm Street, said point being the northwesterly corner of the within described land, thence running in the southerly line of Scovill Street, S 77° 39' 30" E 304.17 feet to a point of curve marked by a drill hole, thence running southeasterly and in a line curving to the right having a radius of 50.285 feet, a central angle of 66° 19' 38"1, a distance of 58.21 feet to a point of compound curve marked by a drill hole, thence running southerly and in a line curving to the right having a radius of 147.42 feet, a central angle of 22° 13' 12", a distance of 57.17 feet to Franklin Street and a point of tangency marked by a drill hole, thence running in the westerly line of Franklin Street S 10° 53' 20" W 320.80 feet to Union Street, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 60.00 feet a distance of 30.95 feet to a point of tangency, the last two described points being connected by a chord having a bearing of S 86° 26' 23" W 30.61 feet, thence running in the northerly line of Union Street N 78° 45' 10" W 223.04 feet to a point of curve marked by a drill hole, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 393.00 feet, a central angle of 14° 30' 02", a distance of 99.46 feet to a point of compound curve marked by a drill hole, thence running northwesterly in a line curving to the right having a radius of 27.56 feet, a central angle of 76° 50' 58", a distance of 37.02 feet to South Elm Street, and a point of tangency, said point being marked by a drill hole, thence running in the easterly line of South Elm Street N 12° 34' 50" E 381.36 feet to Scovill Street and the point of beginning. Said parcel containing 151,285 square feet.

BOUNDED:

NORTHERLY: By Scovill Street

NORTHEASTERLY: by a curved line that connects the southerly line of Scovill Street with the westerly line of Franklin Street
EASTERLY: By Franklin Street

SOUTHERLY: By Union Street

SOUTHWESTERLY: by a curved line that connects the northerly line of Union Street with the easterly line of South Elm Street.
WESTERLY: by South Elm Street.

Being the premises shown on a certain map entitled: "AS-BUILT SURVEY MAP OF LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. JAN. 30, 1980 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 14, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Town Clerk.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C. Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40' " to be filed in the office of the Waterbury Town Clerk.

**2. <u>Parcel Two</u>**

That certain piece of parcel of land situated on the easterly side of South Elm Street, the northerly side of Scovill Street and the southwesterly side of Cole Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin marking the intersection of the easterly line of South Elm Street with the northerly line of Scovill Street, said point being the southwesterly corner of the within described land, thence running in the easterly line of South Elm Street N 11° 43' 24" E 284.60 feet to a point of curve, thence running easterly in a curved line having a radius of 9.70 feet, a central angle of 128° 16', that connects the easterly line of South Elm Street with the southwesterly line of Cole Street, and in a line curving to the right having a distance of 21.72 feet to Cole Street and a point of tangency, thence running in the southwesterly line of Cole Street and tangent to the curve S 40° 00' 36" E 148.72 feet to land now or formerly of Saint Mary's Hospital Corporation, thence running in line of land now or formerly of Saint Mary's Hospital S 11° 43' 24" W, 141.04 feet, S 78° 16' 36" E, 30.29 feet, S 11° 43' 24", 49.70 feet, N 78° 21' 24" W 12.94 feet, N 33° 19' 09" W 8.485 feet, N 77° 58' 50" W 5.85 feet and S 11" 40' W 16.00 feet to Scovill Street, thence running in the northerly line of Scovill Street N 78° 01' 09" W 137.98 feet to South Elm Street and the point of beginning.

BOUNDED:

NORTHERLY: by a curved line that connects the easterly line of South Elm Street with the southwesterly line of Cole Street and by land now or formerly of Saint Mary's Hospital Corporation.

NORTHEASTERLY: by Cole Street.

EASTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHERLY: by Scovill Street and by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHWESTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

WESTERLY: by South Elm Street.

Being the premises shown on a map entitled "MAP SHOWING PARCEL #1 LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. DEC. 28, 1979 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 10, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Clerk.

Together with those easements, covenants, and rights reserved by the Grantor and in a Quit Claim Deed dated January 27, 1988 and recorded February 2, 1988 in Volume 2235, at Page 33 of the Waterbury Land Records and a Corrective Quit Claim Deed dated March 16, 1988 and recorded March 30, 1988 in Volume 2261, at Page 241 of the Waterbury Land Records, in which the Grantor granted to

The Slocum Corporation a certain parcel of land in the City of Waterbury, County of New Haven, State of Connecticut.

Together with those easements, covenants and rights-contained in an Easement Agreement dated September 26, 1988 between and among Saint Mary's Hospital Corporation, Scovill Street Medical Building Association, Inc., and The Slocum Corporation.

Together with those rights contained in a Release of Covenant to Subordinate dated September 26, 1988 between Saint Mary's Hospital Corporation and Scovill Street Medical Building Association, Inc. and recorded in Volume 2364, Page 90 of the Waterbury Land Records.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

**3. <u>Parcel Three</u>**

Grantor's rights to an air space easement granted to Grantor by the City of Waterbury by Quit Claim Deed dated March 18, 1980 and recorded in Volume 1438 at Page 73 of the Waterbury Land Records, said easement being more particularly described as follows:

The air space beginning at a distance of fourteen feet above the said crown of Scovill Street and consisting of all the air space beginning at the said fourteen feet distance above the said crown of Scovill Street) above the following piece or parcel of land:

That certain piece or parcel of land being a portion of Scovill Street situated easterly of South Elm Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin set in the northerly line of Scovill Street, said pin being S 78° 01' 06" E 132.46 feet, from an iron pin that marks the intersection of the northerly line of Scovill Street with the easterly line of South Elm Street as measured in the northerly line of Scovill Street, thence running in the northerly line of Scovill Street S 78° 01' 06" E 80.00 feet, thence running across Scovill Street 11° 58' 54" W 39.99 feet to the southerly line of Scovill Street, thence running in the southerly line of Scovill Street N 77° 39' 30" W Or-' feet, thence running across Scovill Street N 11° 58' 54" E 39.49 feet to the northerly line of Scovill Street and the point of beginning.

**4. <u>Parcel Four</u>**

That parcel of land in the City of Waterbury, County of New Haven, State of Connecticut, shown on map entitled, "Topographic Survey, South Elm St. and Union St., Waterbury, Connecticut. Prepared for Saint Mary's Hospital" scale 1" = 20', dated 2/20/89, revised 4/17/89, last revision 10/9/89, prepared by Kasper Associates, which map is filed with the Town Clerk of Waterbury in Drawer XXVIII, Page 73 and such map has been further revised July 26, 1990, but such further revised map is not intended to be filed on the land records, and which parcel being triangular in shape is described as follows: beginning at a point in the easterly streetline of South Elm Street as shown on said map, said point also being the southwest corner of said parcel thence along the eastern streetline of South Elm Street N.12° 37' 14" E 209.79 feet; thence along a curve concave to the northwest with radius of 15.00 feet, arch length of 23.90 feet and delta of 91° 16' 32"; thence along the southerly street line of Union Street the following two

courses, S 76° 06' 14" E a distance of 413.54 feet and along a curve concave to the south with radius of 1225.00 feet, arc length of 99.17 feet and delta 04° 38' 19" to a C.H.D. monument N. 261898.9378, E 521693.2863, thence S 80° 55' 49" W along monumented highway line of interstate 84 a distance of 559.84 feet; thence S 48° 55' 48" W still along monumented highway line of Interstate 84 a distance of 13.00 feet to the point of beginning.

Said parcel contains 1.30 acres.

(Bounded by Interstate 84, South Elm Street and Union Street)

Together with such rights, if any, as acquired under an Encroachment Agreement by and between the State of Connecticut Department of Transportation and Saint Mary's Hospital Corporation, dated July 31, 1991 and recorded September 12, 1991 in Volume 2774 at Page 229 of the Waterbury Land Records, with respect to a pedestrian link between parcel 4 and parcel 1, as shown on plan entitled "Pedestrian Link Easement Map, Union Street, Waterbury, Connecticut, prepared for Saint Mary's Hospital KA, Kasper Associates, Engineers, Surveyors, Planners, Bethel, Connecticut, Scale 1" = 20', Date: 8/16/89 Sheet 1 of 1 designed by, drawn by, BEM check by JJK, Project No, 2348)

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates, P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

**5. <u>Parcel Five</u>**

That certain parcel of land situated in the Town of Waterbury, County of New Haven and State of Connecticut, on the easterly side of Present Franklin Street, at Present Scovill Street, containing 0.77 of an acre, more or less, bounded and described as follows:

WESTERLY by Present Franklin Street, 303 fees, more or less, by a line designated "Release Line", as shown on the map hereinafter referred to;

WESTERLY,
NORTHWESTERLY
AND NORTHERLY by Present Franklin Street and by Present Scovill Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY by Present Scovill Street, 62 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY,
NORTHEASTERLY
AND EASTERLY by Present Scovill Street and by Present Baldwin Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map

EASTERLY by Present Baldwin Street, 299 feet, more or less, by a line designated "Release Line", as shown on said map;

SOUTHERLY by Present Union Street, 115 feet, more or less, by a line designated "Release Line", as shown on said map.

The above-described land comprises a portion of the premises acquired by the State of Connecticut from Saint Mary's Hospital Corporation as described in a Certificate of Condemnation recorded in Volume 1198 at Page 141 of the Waterbury Land Records; from the City of Waterbury as described in a Quit-Claim Deed recorded in Volume 1206 at Page 109 of said land records; and from Century Brass Products, Inc. as described in a Quit-Claim Deed recorded in Volume 1237 at Page 19 of said land records; and a portion of former Union Street, Baldwin Street and Cole Street.

6. **Parcel Six**

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running
S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

7. **Parcel Seven**

Office Condominium Unit 1A, 133 Scovill Street, Waterbury CT

8. **Parcel Eight**

Office Condominium Unit 2A, 133 Scovill Street, Waterbury CT

9. **Parcel Nine**

Office Condominium Unit 2B, 133 Scovill Street, Waterbury CT

10. **Parcel Ten**

Office Condominium Unit 2C, 133 Scovill Street, Waterbury CT

11. **Parcel Eleven**

Office Condominium Unit 2H, 133 Scovill Street, Waterbury CT

12. **Parcel Twelve**

Office Condominium Unit 2J, 133 Scovill Street, Waterbury CT

**13. Parcel Thirteen**

Office Condominium Unit 2K, 133 Scovill Street, Waterbury CT

**14. Parcel Fourteen**

Office Condominium Unit 3A, 133 Scovill Street, Waterbury CT

**15. Parcel Fifteen**

Office Condominium Unit 3B, 133 Scovill Street, Waterbury CT

**16. Parcel Sixteen**

Office Condominium Unit 3C, 133 Scovill Street, Waterbury CT

**17. Parcel Seventeen**

All that certain plot, piece or parcel of land, together with the improvements located thereon, situated, lying and being in the City of Waterbury, County of New Haven and State of Connecticut, being bounded and described as follows:

Beginning at the Westerly end of a curve connecting the Southerly side of Scovill Street and the Westerly side of South Elm Street;

Running thence in a general easterly direction, on a curve to the right having a radius of 8 feet for a distance of 12.64 feet to the Westerly side of South Elm Street;

Running thence along said Westerly side of South Elm Street, South 12 degrees 36' 46" West 345.35 feet to the Northerly end of a curve connecting said Westerly side of South Elm Street with the Northerly side of Union Street;

Running thence in a general Southwesterly direction on a curve to the right having a radius of 17.00 feet for a distance of 26.73 feet to the Northerly side of Union Street;

Running thence along said Northerly side of Union Street North 77 degrees 17' 05" West 246.85 feet to a point on lands now or formerly of Gulf Oil Corporation;

Running thence along the same, North 12 degrees 42' 55" East 137.39 feet to a point on lands now or formerly of Saint Mary's Hospital Corp.;

Running thence along the same the following courses and distances:

South 77 degrees 58' 14" East, 50.14 feet;
North 12 degrees 01' 46" East, 136.53 feet;
South 75 degrees 32' 14" East, 29.35 feet; and;
North 12 degrees 03' 46" East, 94.73 feet to the Southerly side of Scovill Street;

Running thence along said Southerly side of Scovill Street, South 77 degrees 56' 14" East, 178.40 feet to the point and place of beginning.

Together with and subject to all rights of way, easements and other right and obligation of the grantor appurtenant to the land, including all rights, title and interest of the grantor, if any, in and to the strips and gores, streets, highways and alleys abutting or adjacent thereto.

**18. <u>Parcel Eighteen</u>**

Those three certain pieces or parcels of land, with all the improvements thereon, situated in the City of Waterbury, County of New Haven and State of Connecticut, bounded and described as follows:

FIRST PIECE

That certain piece or parcel of land with all the improvements thereon, situated on the southwesterly corner of East Main Street and Mill Street in the City of Waterbury, County of New Haven and State of Connecticut know as #324-336 East Main Street, bounded and described as follows:

| | |
|---|---|
| NORTHERLY: | 79 feet on East Main Street |
| EASTERLY: | 136 feet on Second Piece; |
| SOUTHERLY: | on land now or formerly of The Church of the Immaculate Conception; and |
| WESTERLY: | 136 feet on land now or formerly of The Church of the Immaculate Conception. |

SECOND PIECE

A certain piece or parcel of land located on the southerly side of East Main Street, being portion of the discontinued Mill Street and is bounded and described as follows:

| | |
|---|---|
| NORTHERLY: | 28.00 feet, more or less, by East Main Street; |
| EASTERLY: | 130.00 feet, more or less, by land now or formerly of the State of Connecticut, acquired by the discontinuance of Mill Street; |
| SOUTHERLY: | 20.00 feet, by land of Century Brass Products, Inc., acquired by the discontinuance of Mill Street; and |
| WESTERLY: | 136.00 feet by land of Philip Avery. |

THIRD PIECE

That certain piece or parcel of land with all the improvements thereon situated in the City of Waterbury, County of New Haven and State of Connecticut, known as EAST MAN STREET, and more particularly bounded and described as follows:

| | |
|---|---|
| NORTHEASTERLY: | 19.86 feet by East Main Street; |
| SOUTHEASTERLY: | 136.00 feet by land now or formerly of Philip Veillette, et al; |
| NORTHEASTERLY: | again 99.25 feet by land now or formerly of Philip Veillette, et |
| SOUTHEASTERLY: | al; again 43 feet, more or less, by Baldwin Street, fka Mill |
| SOUTHEASTERLY: | Street; again |
| SOUTHWESTERLY: | by Baldwin Street, fka Mill Street; |
| NORTHWESTERLY: | 251.25 feet by land now or formerly of the Church of the Immaculate Conception; |
| | 136.68 feet by land now or formerly of the Church of the Immaculate Conception. |

A portion of the parcel is shown on a certain Map entitled, "Map of Land of Scovill Manufacturing Company, Waterbury, Conn., The A.J. Patton Co. Surveyor, Waterbury, Conn. Oct. 1975, Scale 1" = 50' Revised April 9, 1976, Sheet 1 of 8"" on file in the Waterbury Town Clerk's Office in Map Drawer VI,

Page 35.

**Schedule 6.12(b)**

**Leased Real Property**

1. Lease Agreement by and between 1981 East Main Street LLC and Saint Mary's Hospital, Inc. dated May 18, 2010 for property located at 1981 East Main Street, Waterbury, Connecticut.

2. Agreement of Lease, by and between Crosspointe Plaza LLC and Saint Mary's Hospital dated August 18, 2000 for property known as the off-site Naugatuck Walk–In at Crosspointe Plaza Unit Numbers A1 and A2, as amended by the First Amendment to Lease dated April 27, 2009.

3. Lease by and between Fraydun Enterprises LLC and Saint Mary's Hospital Corporation dated December 21, 2004 for property known as The Visitation Building and located at 100 Jefferson Square, First Floor, Waterbury, Connecticut, as amended by the First Amendment to Lease dated February 1, 2010.

4. Lease by and between Fraydun Enterprises LLC and Saint Mary's Hospital Corporation dated December 21, 2004 for property known as The Visitation Building and located at 100 Jefferson Square, Lower Level, Waterbury, Connecticut, as amended by the First Amendment to Lease dated February 1, 2010.

5. Lease by and between The Slocum Corporation and Saint Mary's Hospital Corporation dated October 1, 2002 for property at the medical building located at Scovill Street and Cole Street.

6. Lease by and between Scovill Commons Partners LLC and Saint Mary's Hospital, Inc. dated November 18, 2005 for property located at 95 Scovill Street, Pavilion B, Second Floor, Waterbury, Connecticut, as amended by the First Amendment to Lease dated September 10, 2007.

7. Lease by and between Scovill Commons Partners LLC and Saint Mary's Hospital Corporation dated March 1, 2006 for property located at 95 Scovill Street, Pavilion B, Third Floor, Waterbury, Connecticut.

8. Lease by and between Paolo Mapelli and Saint Mary's Hospital, Inc. dated January 1, 2006 for property known as the Scovill Medical Center and located at 133 Scovill Street, Suite 206, Waterbury, Connecticut, as modified by the Lease Modification Agreement, dated January 1, 2009.

9. Commercial Lease by and between Metcalf Realty LLC and Saint Mary's Hospital, Inc. dated September 1, 2007 for property known as Bullet Hill Park and located at 33 Bullet Hill Road, Building A – Main Level, Southbury, Connecticut.

10. Lease by and between West Main Medical LLC and Saint Mary's Hospital, Inc. dated March 2004 for property located at 1312 West Main Street, Waterbury, Connecticut, as amended by the Amendment to Lease dated October 2004.

11. Indenture of Lease by and between Park West LLC and Saint Mary's Hospital dated March 21, 2002 for property located at 1320 West Main Street and Park Road in Waterbury, Connecticut, as amended by (i) the Amendment to Lease Agreement dated October 23, 2003 and (ii) the Second Amendment to Lease dated November 2004.

12. Lease by and between Spectrum Square LLC and Saint Mary's Hospital Corporation, Inc. dated February 24, 2004 for property located at 503 Wolcott Road, Second Floor, Wolcott, Connecticut, as amended by the Amended and Restated Lease dated April 1, 2006.

13. Lease by and between Southbury Properties Limited Partnership and Scovill Medical Group, P.C. dated February 1, 1997 for property known as the Union Square Shopping Center and located at Main Street South and Peter Road, Southbury, Connecticut, as modified by (i) the Sublease Agreement, dated May 1, 1998, (ii) the Amendment of Lease dated July 1999, (iii) the Amendment of Lease dated August 1, 1999, (iv) the Assignment of Leases and Security Deposits dated February 25, 2004 and (v) the Assignment, Third Amendment and Extension of Lease dated May 2006.

14. Commercial Lease Agreement by and between 146 Highland Associates LLC and Saint Mary's Hospital, Inc. dated January 2011 for property located at 146 Highland Avenue, Waterbury, Connecticut.

15. Lease Agreement by and between The Harold Leever Regional Cancer Center, Inc. and Saint Mary's Hospital, Inc., dated June 1, 2014 for property located at 1075 Chase Parkway, Waterbury, Connecticut.

16. Office Sublease Agreement by and between D'Vine Medical Spa LLC and Franklin Medical Group, P.C., dated September 30, 2013, for property located at 590 Middlebury Road, Middlebury, Connecticut.

17. Office Sublease Agreement by and between Primary Care Partners, P.C., and Saint Mary's Hospital, Inc., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

18. Office Lease Agreement by and between Prospect Medical, LLC, and Saint Mary's Hospital, Inc., dated December 1, 2010, for property located at 166 Waterbury Road, Suite 202, Prospect, Connecticut.

19. Lease Agreement by and between French's Mill Associates II LLP and Naugatuck Valley Surgical Center Limited Partnership, dated December 1, 2009, for property located at 160 Robbins Street, Waterbury, Connecticut

20. Indenture of Lease by and between Medical Investors L.L.C. and Saint Mary's Hospital, Inc., dated December 2, 2010 for property located at 70 Heminway Park Road, Watertown, Connecticut.

21. Lease Agreement by and between 1177, LLC and Franklin Medical Group, Inc., dated August 26, 2014, for property located at 1177 New Haven Road, Naugatuck, Connecticut.

22. Sublease Agreement by and between Westside Medical Group, P.C., and Franklin Medical Group, P.C., dated September 1, 2014, for property located at 714 Chase Parkway, Waterbury, Connecticut.

23. Lease by and between Edward I. Bushka and Margarita Bushka and Franklin Medical Group, dated July 22, 2014, for property located at 60 Westwood Avenue, Waterbury, Connecticut.

24. Lease by and between LJL Property, LLC, and Saint Mary's Hospital, Inc., dated June 17, 2015, for property located at 3528 East Main, Waterbury, Connecticut.

25. Lease by and between Bradley Medical Building Associates, L.L.C., and Franklin Medical Group, P.C., dated July 1, 2014, for property located at 55 Meriden Avenue, Suite 3C, Southington, Connecticut.

26. Lease by and between RPG Highland LLC and Saint Mary's Hospital, Inc., dated July 13, 2015, for property located at 1154 Highland Avenue, Cheshire, Connecticut.

27. Lease Agreement by and between Arev Three Limited Partnership and Ellen G. Polokoff, M.D., LLC, dated May 10, 2007, for property located at 900 Main Street South, Southbury, Connecticut, as amended by a First Amendment, dated September 30, 2009, a Second Amendment, dated November 30, 2011, and a Third Amendment, dated December 30, 2013. Ellen G. Polokoff M.D., LLC, assigned the lease to Franklin Medical Group, P.C., effective April 20, 2015.

28. Agreement of Lease by and between 385 Union Square Realty LLC and Comprehensive Health Care, LLC, dated October 2005, for property located at 385 Main Street South, Southbury, Connecticut, as amended by First Amendment, dated January 2009, and Second Amendment, dated April 2014. Agreement of Lease was assigned to Franklin Medical Group, P.C., effective July 31, 2015.

29. Office Lease, as amended, by and between Prospect Office LLC and Waterbury Primary Care Associates, P.C., dated December 2, 2004, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut. Office Lease assigned to Prospect Medical LLC, effective January 2008.

30. Office Sublease Agreement, by and between Primary Care Partners, P.C., and Saint Mary's Hospital, Inc., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

31. Office Sublease Agreement, by and between Primary Care Partners, P.C., and Franklin Medical Group, P.C., dated January 1, 2011, for property located at 166 Waterbury Road, Suite 300, Prospect, Connecticut.

**Schedule 6.14(a)**

**Legal Proceedings**

***Don Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***
***Brian Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***
***George Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***
***Patrick Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***

In each of the *Doe* matters, the plaintiffs allege that they were victims of sexual molestation perpetrated by the same priest while patients at Saint Mary's Hospital in the 1970s. The George Doe case was mediated before Judge Zemetis on June 30, 2015. The case was settled for $500,000 and will be paid in full by Travelers Insurance Company. Because the plaintiff was in bankruptcy, the settlement is subject to bankruptcy court approval. The remaining three *Doe* matters are being scheduled for mediation. Because Travelers filed a reservation of rights in 2008, Travelers has not affirmed coverage of the remaining three cases but is expected to provide coverage in full.

**Schedule 6.14(b)**

**Governmental Orders**

None.

**Schedule 6.15(a)**

**Compliance with Laws**

**Schedule 6.16(a)**

**Medicare - Plans of Correction**

None.

**Schedule 6.16(b)**

**Medicare - Claims**

Other than routine claims for reimbursement before RAC/MAC made in the ordinary course of business and to the knowledge of Saint Mary's, there are no claims, actions, or appeals pending before any commission, board or agency, including any fiscal intermediary or carrier, the Provider Reimbursement Review Board or the Administrator of the Centers for Medicare and Medicaid Services, with respect to Government Program claims filed on behalf of the Saint Mary's Providers or, to the Knowledge of Saint Mary's, the Joint Ventures

**Schedule 6.16(d)**

**Medicare - Accreditation Surveys/Deficiency Lists**

None.

**Schedule 6.19**

**HIPAA - Breach Notifications**

**Schedule 6.20**

**Affiliate Transactions**

**Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.**

1. James C. Smith -Chairman and CEO of Webster Financial Corporation - Saint Mary's is subject to a loan agreement and revolving note with Webster Bank. See Schedule 6.09

2. S. Mark Albini, M.D. - Dr. Albini provides services to Saint Mary's Hospital pursuant to an Administrative Services Agreement, as amended, between Saint Mary's Hospital and Dr. Albini, dated October 1, 2003. Dr. Albini is also subject to an ACO Medical Director Agreement with Saint Mary's Physician Partners, dated December 1, 2014

3. James Uberti, M.D. - Dr. Uberti provides physician services to Franklin Medical Group pursuant to a Physician Employment Agreement, as amended, by and between Dr. Uberti and Franklin Medical Group, dated October 1, 2012

4. Michael Karnasiewicz, M.D. is the president of Neuro Enterprises, LLC which is party to a Neurosurgery Service Line Co-Management Agreement, dated May 1, 2015, by and between Saint Mary's Hospital, Inc., and Neuro Enterprises, LLC

**Franklin Medical Group, P.C.**

The following physicians sit on the Board of Directors for Franklin Medical Group, P.C. and are also subject to employment agreements with Franklin Medical Group. See **Schedule 6.09**.

1. Rohit Beri, M.D.

2. Laura Brenes, M.D.

3. Philip Corvo, M.D.

4. Jason Ouellette, M.D.

5. Alex Palesty, M.D.

6. Michael Simms, M.D.

7. John Testa, M.D.

8. Steven Schneider, M.D.

9. James Uberti, M.D. - See above

**Schedule 6.21(e)**

**Environmental**

1. Underground Storage Tank Closure/Installation Report, dated November 25, 1997, prepared by Coneco Environmental Corporation – CT

2. Fuel Analysis Report, dated January 27, 2011, for 20,000-gallon No. 2 oil tank and 5,000-gallon diesel tank

3. Certified Tank Tightness Inspection Report, dated January 14, 2011, for the 5,000-gallon diesel generator tank

4. Certified Tank Tightness Inspection Report, dated December 30, 2010, for the 5,000-gallon diesel generator tank

5. Certified Tank Tightness Inspection Report, dated December 30, 2010, for the 20,000-gallon No. 2 fuel oil tank

6. Cathodic Test inspection Report, dated December 3, 2010, for the 20,000-gallon No. 2 Oil Tank and the 5,000-gallon diesel fuel tank

7. Saint Mary's Hospital Asbestos Operations and Maintenance Program, Revision date July 1993

8. Asbestos Building Assessment, dated July 1990, prepared by TRC Environmental Consultants, Inc.

9. Operations and Maintenance Program (for Asbestos-Containing Materials), dated September 1990, prepared by TRC Environmental Consultants, Inc.

10. Letter, dated August 3, 1990, from Asbestos Abatement & Insulation Services, Inc. re: asbestos abatement contract for the Xavier Attic at Saint Mary's Hospital

11. Asbestos Abatement Monitoring and Pre-Renovation Documents for Saint Mary's Elevator Lobby, dated August 19, 2008, prepared by Eagle Environmental

12. Asbestos Removal Specifications for Slocum 4, dated August 7, 1998

13. Asbestos Operations and Maintenance Program, undated

14. Asbestos Disposal and Documentation Form, #22762, dated October 23, 2008

15. Asbestos Disposal and Documentation Form, #99 91358, landfill date November 18, 2005

16. Asbestos Disposal and Documentation Form, #99 63869, landfill date November 18, 2005

17. Final Report for Asbestos Abatement Project, Emergency Room Phase IIA, dated November 29, 2005, prepared by EnviroScience Consultants Inc.

18. Letter from White Insulation, Inc., dated March 10, 2010, enclosing paperwork re: removal and disposal of asbestos containing materials from the Lawlor Building

19. Letter from White Insulation, Inc., dated August 28, 2008, enclosing paperwork re: removal and disposal of asbestos containing materials from the fourth floor of Saint Mary's Hospital

20. Pre-Renovation Hazardous Building Materials Inspection of Saint Mary's Existing Main Entrance Lobby, dated June 27, 2007, prepared by Eagle Environmental, Inc.

21. Bulk Sample Collection and Analysis of Central Supply Decontamination Room, dated December 13, 2007, prepared by Eagle Environmental, Inc.

22. Bulk Sample Collection and Analysis of Saint Mary's Front Entrance, dated May 16, 2007, prepared by Eagle Environmental, Inc.

23. Hazardous Building Materials Inspection, Abatement Design and Monitoring Services of Saint Mary's Existing Main Entrance Lobby, dated May 16, 2007, prepared by Eagle Environmental, Inc.

24. Proposal from Eagle Environmental, Inc., dated January 25, 2008, re: Asbestos Containing Materials Re-occupancy Services

25. Bulk Sample Collection and Analysis of Kenny Building-2nd Floor Operating Room, dated January 11, 2008, prepared by Eagle Environmental, Inc.

26. Limited Asbestos Inspection Report, dated June 4, 2010, prepared by Superior Industries LLC

27. Letter from White Insulation, Inc., dated August 28, 2008, enclosing copies of waste manifests for asbestos containing materials removed from Saint Mary's Hospital

28. Asbestos Analysis of Bulk Materials in the Kenny Building and Conference Center 5th Floor, dated February 10, 2010, prepared by Superior Industries L.L.C.

29. Letter from White Insulation, Inc., dated July 17, 2008, enclosing copies of waste manifests for asbestos containing materials removed from Saint Mary's Hospital

30. Letter from White Insulation, Inc., dated October 19, 2006, enclosing a copy of a waste manifest for asbestos containing materials removed from Saint Mary's Hospital

31. Letter from White Insulation, Inc., received by Saint Mary's on June 27, 2007, enclosing paperwork re: removal and disposal of asbestos containing materials from Saint Mary's

32. Letter from ChemScope, dated May 27, 1994, re: bulk asbestos samples from Saint Mary's Hospital

33. Asbestos Pre-Renovation Inspection for O'Brien Roof Renovation, dated June 4, 2004, prepared by ChemScope

34. Asbestos Removal Monitoring for O'Brien Building for May 29, 1997 to July 11, 1997, prepared by ChemScope

35. Bulk Sample Collection and Analysis of Saint Mary's Elevator Lobby, dated December 4, 2007, prepared by Eagle Environmental, Inc.

36. Letter from Superior Industries, L.L.C., dated December 15, 2010, re: asbestos testing in Xavier Room 232A area

37. Letter from White Insulation, Inc., dated October 23, 2007, enclosing waste manifest for asbestos containing materials abated at Saint Mary's

38. Asbestos Analysis of Bulk Materials in Xavier, dated January 8, 2011, prepared by Superior Industries L.L.C.

39. Letter from Eagle Environmental, Inc., dated September 6, 2007, re: proposal to provide a pre-renovation asbestos containing materials

40. Asbestos Removal Manual for Saint Mary's Foyer Renovation, prepared by Eagle Environmental, Inc.

41. Letter from Eagle Environmental, Inc., dated August 1, 2007, re: proposal to provide asbestos abatement services for the renovation of the Main entrance lobby

42. Bulk Sample Collection and Analysis for Saint Mary's Elevator Lobby, dated December 4, 2007, prepared by Eagle Environmental, Inc.

43. Asbestos Disposal and Documentation Form, #142365, landfill date August 11, 2008

44. Asbestos Disposal and Documentation Form, #142366, landfill date August 11, 2008

45. Asbestos Disposal and Documentation Form, #142354, landfill date August 11, 2008

46. Uniform Hazardous Waste Manifest, # 002053366, landfill date September 15, 2008

47. Letter from ChemScope, dated July 30, 1993, enclosing copy of Asbestos O&M Program

48. Restatement of Policy Requirements for handling the spray on fireproofing found in the ceiling spaces of the O'Brien Building, floors 6, 7, and 8, dated April 16, 1991, prepared by TRC Environmental Consultants, Inc.

49. Report from TRC, dated January 21, 1986, re: asbestos project work conducted at Saint Mary's in January 1986

50. Letter from ChemScope, dated December 4, 1991, re: results from bulk samples

51. Letter from ChemScope, dated September 10, 1993, re: results from bulk samples

52. Letter from ChemScope, dated June 13, 1991, enclosing copies of final clearance testing after asbestos abatement for O'Brien 6, 7, and 8 elevator

53. Asbestos Abatement Specifications/Invitation to Bid, prepared by ChemScope Inc., dated March 4, 1991

54. ACM Monitoring Main Entrance Lobby Renovation Project, dated December 20, 2007, prepared by Eagle Environmental, Inc.

55. Bulk Sampling/Analysis Record for Boiler House – New D.A. Tank Room, dated November 20 (year unclear – possibly 1992)

56. Asbestos Abatement Report for MOB Elevator Lobby and CAT Scan, dated December 17, 1993, prepared by AEGIS Inc.

57. Report, dated August 4, 1994, prepared by ChemScope re: Asbestos Removal Monitoring of O'Brien 6-Mechanical Rooms and Adjacent Office Asbestos Removal Monitoring from June 13, 1994 through July 30, 1994

58. Asbestos Removal Specifications for O'Brien 6, dated May 2, 1994

59. Asbestos Abatement Report for Xavier Basement Mechanical room, dated March 24, 1994, prepared by AEGIS Inc.

60. Asbestos Abatement Project Site Monitoring Report for December 18, 1995 through February 8, 1996 for O'Brien 7, prepared by Mystic Air Quality Consultants, Inc.

61. Final Documentation Package for Asbestos Removal in MOB Elevator Lobby and CAT Scan, dated January 7, 1994, prepared by Haz-Pros, Inc.

62. Letter from AAIS, dated February 16, 1994, enclosing disposal documentation for various asbestos abatement and removal projects at Saint Mary's Hospital

63. Asbestos Removal Specifications for Xavier Attics, dated July 25, 1990

64. Certificate of Completion and Disposal Documentation Form for Abatement of Nun's Dining Room, dated October 1990

65. Letter from Acstar Insurance Company, dated July 10, 1991, re: status of bond concerning the Xavier and Slocum Basements

66. AAIS Certification of Payment of all Debts and Claims concerning Slocum and Xavier Basements, dated June 26, 1991

67. Letter from TRC, dated August 15, 1990, re: Justification for Alternative Work Practices

68. Letter from TRC, dated November 6, 1990, re: Completion of Asbestos Abatement of Slocum and Xavier Crawlspaces

69. AAIS Certification of Completion of abatement of crawl spaced, received October 26, 1990, enclosing copy of the Asbestos Abatement Project Notification Form and Asbestos Disposal and Documentation Form

70. Report on Fibrous Dust in Air Analysis, dated October 16, 1990, prepared by Environmental Hazard Control Associates, Inc.

71. Performance Bond, dated September 20, 1990, issued by the American Institute of Architects to AAIS in the amount of $38,500.00

72. Documentation of Approved Disposal of Asbestos Waste, dated September 1990 and October 1990

73. Asbestos Abatement Project Notification Form for work to be completed by September 5, 1990 (may be duplicate of Xavier Attic)

74. Asbestos Removal Specifications for Saint Mary's Penthouse, dated August 7, 1990, prepared by ChemScope

75. Final Inspection of Asbestos Clean-up Action, dated June 20, 1989, prepared by Statewide Environmental Services re: clean-up of electrical box

76. Approval for Special Waste Disposal – Asbestos, dated September 30, 1987, issued by the CTDEP

77. Letter from Saint Mary's, dated January 15, 1988, re: asbestos removal at Saint Mary's Hospital

78. Letter from Marsh &McLennan, dated January 26, 1988, re: asbestos removal at Saint Mary's Hospital

79. Letter from Manville Property Damage Settlement Trust, dated August 7 1989, re: filing first-cycle claims

80. Letter from Saint Mary's, dated July 20, 1987, re: scope of asbestos removal in boiler room and adjacent areas

81. Letter from Sitewide Environmental Services, dated May 19, 1988, re: disposal of asbestos from Saint Mary's at S&S Landfill in Clarkburg, West Virginia

82. Saint Mary's internal memorandum, dated March 29, 1988, re: amount of liability insurance for asbestos removal project

83. Saint Mary's internal memorandum, dated January 25, 1989, re: asbestos removal from the gift shop

84. Asbestos Removal Documentation for removal of 40 linear feet of asbestos pipe covering in March/April 1989

85. Non-hazardous Special Waste Manifests, dated November 19, 1990

86. Invoice from Ever Clear, dated April 30, 1990, re: removal of 135 feet of pipe covering

87. Asbestos removal documentation from Ever Clear re: removal of asbestos from valves and tees in mechanical room

88. Asbestos Fiber Analysis by Transmission Electron Microscopy, Selective Area Electron Diffraction and Energy Dispersive X-Ray Microanalysis, dated August 11, 1990, prepared by EMSL

89. Asbestos Preventative Maintenance Record, dated June 23, 1989, re: asbestos removal from pipe located in Xavier Attic for 3 inch steam line repair

90. Asbestos Preventative Maintenance Record, dated September 1, 1987, to change pressure regulating valve on heating system

91. Asbestos Preventive Maintenance Record, dated March 3, 1987, to remove make up water pump

92. Asbestos Preventive Maintenance Record, dated January 29, 1987, to make repairs to HAVAC unit

93. Asbestos Preventive Maintenance Record dated January 9, 1987, re: accidentally disturbed asbestos while making plumbing repair over top of boiler

94. Asbestos Preventive Maintenance Record, dated June 11, 1986, re: high pressure steam line leaking

95. Asbestos Preventive Maintenance Record, dated June 9, 1986, re: steam leak

96. Saint Mary's Interoffice Memorandum, dated January 13, 1986, re: removal of four barrels of asbestos

97. Approval for Special Waste Disposal Asbestos, dated May 13, 1985, issued CTDEP

98. Asbestos Preventive Maintenance Record, dated August 7, 1985, re: removal of duct to incinerator double plastic

99. Asbestos Preventive Maintenance Record, dated July 29, 1985, re: future removal of incinerator in School of Nursing

100. Asbestos Preventive Maintenance Record, dated March 9, 1985, re: removed asbestos because it was loose

101. Asbestos Preventive Maintenance Record, dated January 17, 1985, re: notification by manufacture and insulation replacement provided by Air Shield

102. Asbestos Preventive Maintenance Record, dated September 11 and 12, 1984, re: facilitate removal of head from heat exchanger in OB-SB

103. Asbestos Preventive Maintenance Record, dated January 25, 1984, re: remove pipe insulation to disconnect chill water coil

104. Asbestos Preventive Maintenance Record, dated January 2, 1984, re: water leak in SA city water bypass

105. Asbestos Preventive Maintenance Record, dated December 20, 1983, re: removal of asbestos from piping on hot water heater

106. Charge ticket from City of Waterbury – Solid and Liquid Waste Disposal, dated October 23, 1985

107. Approval for Special Waste Disposal – Asbestos, dated May 11, 1987, issued by the CTDEP

108. Saint Mary's Policy re: A.C.M. Asbestos Containing Material, dated December 30, 1985

109. Saint Mary's Interoffice Memorandum, dated June 20, 1983, re: asbestos removal on June 16, 1983

110. Saint Mary's Engineering Policy and Procedure Manual, dated December 6, 1983, re: Removal of Asbestos Insulation

111. Saint Mary's Interoffice Memorandum, dated April 21, 1980, re: Asbestos Fiber Containment

112. Saint Mary's internal memorandum, dated April 4, 1985, re: asbestos tests

113. Asbestos Removal Monitoring invoices, contracts, specifications, laboratory results, pre-abatement inspections and project summaries for the Courtyard Roof and Dietary Mechanical Room, dated December 1992 – February 1993

114. Ambient Air Asbestos Testing, Asbestos Project Summaries, Air Samples, Asbestos Worker Certifications, dated January 1992 – March 1992 and CTDPH Application for Approval of Alternative Work Practice, dated December 26, 1991

115. Asbestos Removal Monitoring for the Boiler Room Office, DA Tank Room and O'Brien 4 Mechanical Room, dated February 1, 1993 – February 4, 1993

116. Asbestos Disposal & Documentation Form, dated August 27, 1993

117. Asbestos Disposal & Documentation Form, dated August 11, 1993

118. Asbestos Abatement Report, MRI Hall, KB49 and KB50 prepared by Aegis, Inc. Environmental Consultants, dated November 4, 1993

119. Asbestos Disposal & Documentation Form, dated November 8, 1993

120. AEGIS Analytical Report, dated November 1993

121. Logano Asbestos Disposal & Documentation Form, dated November 8, 1993

122. AAIS Certificate of Completion, dated August 25, 1993, for asbestos removal on 1st & 2nd Floors of O'Brien Wing

123. AAIS Proposed Scope of Work letter, dated May 18, 1993, for the elevator lobby on 5th floor

124. AAIS Certificate of Completion and related documentation for Kinney X-Ray 4 & 5, dated November 1, 2004

125. ChemScope Asbestos Pre-Renovation Inspection for Kenny 1 Radiology Hallways Floor Tile, dated November 19, 2004

126. ChemScope Bulk Sample Identification and Findings, dated July 10, 1996

127. ChemScope Asbestos Abatement Specifications for O'Brien 8 (no drawings included), dated October 28, 1996

128. ChemScope Asbestos Removal Specifications for O'Brien 8, dated October 28, 1996

129. ChemScope Asbestos Removal Specifications for O'Brien 8, dated July 24, 1997

130. ChemScope Bulk Sample Identification and Findings, dated March 6, 1992

131. ChemScope Monitoring and Air Sampling for Mammography and Elevators 9 and 10, dated March 16, 1992 – March 17, 1992

132. ChemScope Monitoring and Air Sampling for ER Radiology Sections I & II, dated April 20, 1992 – April 21, 1992

133. AAIS Certificate of Completion for Asbestos Removal at the 3rd Floor Garage Elevator / Sections I & II Lobby, dated August 1992

134. ChemScope Bulk Sample Identification and Findings, dated November 23, 1992

135. Saint Mary's Bulk Sampling / Analysis Record Results for Boiler House – New D.A. Tank Room, dated November 13, 1992

136. AEGIS Air Monitoring Report, dated February 5, 1993

137. ChemScope Bulk Sample Identification and Findings, dated January 13, 1992

138. ChemScope Bulk Sampling / Analysis Record for O'Brien 5, dated January 13, 1992

139. CT Department of Health Services Asbestos Abatement Notification Form, dated July 22, 1991

140. Logano Asbestos Disposal & Documentation form, dated March 20, 1992

141. Logano Asbestos Disposal & Documentation forms, dated March 5, 1992

142. AAIS Certificate of Completion for Asbestos Removal at O'Brien Cafeteria Entrance, O'Brien Basement and O'Brien Subbasement Connector, dated March 30, 1992

143. ChemScope Bulk Sample Identification and Findings, dated January 9, 1992

144. ChemScope Air Sampling Results for 3rd Floor Garage Elevator Area Sections I and II, dated July 11, 1992

145. AEGIS Analytical Reports, dated March 5, 1992

146. ChemScope Bulk Sample Identification and Findings, dated July 28, 1992

147. Asbestos Abatement Specifications for the O'Brien Laboratory Department, 2nd Floor, dated November 8, 1991

148. ChemScope Bulk Sample Identification and Findings, dated November 25, 1991

149. TRC Request for Confirmation regarding asbestos work in the Basement and 5th Floor, dated January 29, 1991

150. ChemScope Ambient Asbestos Air Samples, dated July 23, 1990

151. TRC Asbestos Building Assessment, dated July 1990

152. TRC Summary Report – Quarterly Air Monitoring, dated June 1991

153. TRC Summary Report – Asbestos Removal Activities, dated December 1990

154. TRC Summary Report – Quarterly Air Monitoring, dated January 1991

155. AEGIS Report of Ambient Air Sampling, dated December 10, 1991

156. ChemScope Asbestos Sample Identification, dated October 31, 1991

157. ChemScope Bulk Sample Identification and Findings, dated January 9, 1992

158. Various Basement Sampling Results, dated December 27, 1991

159. ChemScope Bulk Sample Identification and Findings, dated May 28, 1991

160. ChemScope Bulk Sample Identification and Findings, dated April 1991

161. EnviroMed Laboratory Analysis Reports, dated April 1991

162. Declaration of Fran Fahy that there is asbestos in the ceiling of Radiation Therapy, dated September 11, 1990

163. Ever Clear Final Sample Test Report, dated May 31, 1990

164. ChemScope Post Abatement Asbestos Air Samples, dated August 31, 1990

165. ChemScope Asbestos Removal Monitoring for the Boiler Room, dated August 23, 1990

166. ChemScope Ambient Air Samples from Boiler Room, dated July 23, 1990

167. ChemScope Asbestos Air Samples, dated April and May 1988

168. Statewide Environmental Services Air Sampling for Friable Asbestos, dated October 3, 1988

169. ChemScope Asbestos Removal Monitoring for Xavier Attics North/South, dated September 1, 1990

170. Saint Mary's Memorandum regarding TRC Air Samples, dated August 7, 1990

171. TRC Verification of Sample Analysis for debris in the Boiler Room, dated July 25, 1990

172. TRC Physician's Notification of Requirement of Physical Examinations, dated April 16, 1991

173. TRC Completion of Asbestos Removal and Cleanup for the Boiler Room and Xavier North/South Attics, dated September 14, 1990

174. TRC letter regarding properly managing asbestos and the Hospital's liability, dated July 30, 1990

175. TRC handwritten letter regarding the floor locations to be inspected as part of the Asbestos Management Program, dated August 10, 1990

176. ChemScope Asbestos Removal Specifications for the Kenny Basement, dated May 29, 1997

177. ChemScope Asbestos Removal Specifications OB SB-1, Mechanical Room, K1 Radiology Rooms 1 & 2, Dark Room, Slocum Pipe Chase Levels B thru 4 and SH Condensate Pump Room, dated January 30, 1997

178. Asbestos Removal and Area Decontamination – Supplementary General Conditions (starts with Table of Contents)

179. ChemScope Asbestos Removal Monitoring for the Kenny Building, 1st Floor, Radiology Room 2 for July 8, 1997 through July 9, 1997, dated July 23, 1997

180. ChemScope Asbestos Removal Monitoring for the Kenny Building, 1st Floor, Radiology Room 2 for July 10, 1997 through July 16, 1997, dated July 23, 1997

181. ChemScope Final Clearance Testing After Asbestos Abatement, dated July 21, 1997

182. ChemScope Asbestos Bulk Sampling for O'Brien 6 Penthouse (mud on exposed ends of fiberglass insulated lines adjacent to heating and chilled water pumps), dated November 13, 2001

183. ChemScope Asbestos Bulk Sampling for O'Brien 5 PT Gym Room Floor Tile and Mastic, dated November 29, 2001

184. Certificate of Completion and related documents for O'Brien 1st Floor, dated April 4, 2001

185. Certificate of Completion and related documents for Kenny Basement Stairwell Tile, dated October 11, 2000

186. Certificate of Completion and related documents for Pick Up & Disposal, dated August 10, 2000

187. ChemScope Asbestos Pre-Renovation Inspection for O'Brien 1 – Inpatient Mental Health – Hellman Pavilion, dated February 11, 1999

188. Asbestos Air Monitoring, dated February 22-23, 1999, prepared by Dale Environmental, Inc.

189. ChemScope Bulk Sampling / Analysis Record for O'Brien - Inpatient Mental Health – Hellman Pavilion, dated February 1999

190. Asbestos Inspection, dated February 3, 1999, prepared by Dale Environmental, Inc.

191. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #5, dated July 16, 1999

192. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #4, dated July 16, 1999

193. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #1, dated July 16, 1999

194. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #3, dated July 16, 1999

195. Asbestos Abatement Specification for Cardiac Cath Lab, 2nd Floor, Sacred Heart Building, dated February 1999, prepared by Dale Environmental, Inc.

196. ChemScope Asbestos Pre-Renovation Inspection for Xavier 1 Auxiliary Office Area, dated February 12, 1998

197. ChemScope Asbestos Removal Monitoring for February 21, 1997 through March 8, 1997, dated March 31, 1997

198. Internal Memorandum regarding the Status of the Manville Property Damage Settlement Trust and related documents including claim payment information, dated 1996-1997

199. ChemScope Bulk Sample Identification and Findings (submitted as evidence for the Manville Property Damage Settlement), dated July 27, 1991 – May 13, 1995

200. AEGIS Certificate of Visual Inspection, dated March 23, 1994

201. Notification to the EPA of Demolition and Renovation Activities for MRI-KB, dated October 1, 1993

202. List of Asbestos Removal Areas/Costs from 1987 to Present, dated February 26, 1991

203. List of Asbestos Monitoring Areas/Costs from July 1990 to Present, dated February 26, 1991

204. AAIS Certificate of Completion of Asbestos Removal at Saint Mary's Hospital O'Brien Elevator Project and related Asbestos Disposal & Documentation Forms and Asbestos Abatement Notification Form

205. Letter from ChemScope, dated April 17, 1989, re: Asbestos Identification in Samples

206. Letter from TRC, dated November 30, 1990, re: Draft Scope of Asbestos Work

207. Letter from TRC, dated October 3, 1990, re: Saint Mary's Hospital Asbestos Management Program

208. Letter from Cannon, dated August 14, 1990, re: vinyl asbestos tile in the Kenny Pavilion

209. Letter from TRC, dated August 10, 1990, re: Inspections of Parking Garage and Convent Building

210. Letter from ChemScope, dated July 22, 1990, re: Air Monitoring at Saint Mary's Hospital Boiler Room Asbestos Removal, Pipe Residuals

211. Letter from TRC, dated December 18, 1990, re: completion of removal of vinyl asbestos floor tile from the old vending machine room

212. ChemScope Certificate of Analysis, dated February 17, 1998, re: bulk samples collected on February 12, 1998

213. Asbestos Disposal and Documentation Form, dated January 21, 1997

214. Asbestos Disposal and Documentation Form, dated September 6, 1996

215. Disposal documents, air sampling results, and asbestos removal monitoring re: asbestos abatement of Marley Tower in September 1991

216. Disposal documents, air sampling results, and asbestos removal monitoring re: asbestos abatement of Quality Assurance Office Area 2 in July 1991

217. AAIS Certificate of Completion, dated November 23, 1993, re: asbestos removal at MRI KB-49 and KB-50

218. Letter, dated August 6, 1990, from TRC Environmental Consultants, Inc. re: Transmission Electron Microscope Analysis of Air Samples

219. Asbestos Disposal & Documentation Form for the Xavier Attic

220. Asbestos Abatement Project Notification Form for the Xavier Attic

221. Asbestos Project Summary and Asbestos Preabatement Inspection, prepared by ChemScope, for the Xavier Attic

222. ChemScope Asbestos Pre-Renovation Inspection for Roof Renovation – O'Brien 8 Roof, dated June 2004

223. American Hospital Association letter regarding Claim Forms for Filing Claims with the Manville Property Damage Settlement Trust, dated May 1985

224. Specifications for Procedures to Prevent Asbestos Contamination and Exposure During Containment Construction for Asbestos Abatement Work, dated August 1990

225. NHD Waste Shipment Record, dated July 16, 1997

226. ChemScope Final Clearance Testing After Asbestos Abatement for 1st Floor O'Brien Inpatient Mental Health – Hellman Pavilion – Area #2, dated July 16, 1999

227. Notification of Regulated Waste Activity, dated January 12, 2000

228. Saint Mary's Hospital Hazardous Materials Management Program, dated March 5, 2009; Revised March 6, 2009

229. 2009 Biennial Hazardous Waste Report for Saint Mary's Hospital, submitted by GZA GeoEnvironmental, Inc. on February 26, 2010

230. Budgetary Quotation, dated February 25, 2010, from United Industrial Services to Saint Mary's Hospital

231. Course Outline for Saint Mary's Hospital Hazardous Waste Training RCRA-OSHA-DOT Sessions 1, 2, and 3

232. List of Hazardous Material and Waste Storage Areas

233. Tier II Emergency and Hazardous Chemical Inventory Form Certification for Reporting Year 2009

234. Anesthetic Waste Gas Monitoring Report, dated November 2, 2009, prepared by Praxair

235. Anesthetic Waste Gas Monitoring Report, dated May 1, 2009, prepared by Praxair

236. Ethylene Oxide Environmental Monitoring Report, dated May 1, 2009, prepared by Praxair

237. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2007

238. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2006

239. Compliance Indicator Survey Information Sheet/Hazardous Waste Partial Compliance Evaluation for Saint Mary's Hospital, dated June 27, 2006

240. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2005

241. Tier II Emergency and Hazardous Chemical Inventory Report for Reporting Year 2003

242. CT DEP Permit to Operate a Caterpillar D-349 Diesel Generator, No. 192-0093

243. CT DEP Permit to Construct and Operate a Caterpillar Model 3508TA diesel standby generator, No. 192-0116

244. Saint Mary's Compliance Plan for Connecticut Regulations for the Control of Oxides of Nitrogen, dated August 1994

245. Pre-Inspection Questionnaire (PIQ) for Calendar Year 1999

246. Pre-Inspection Questionnaire Report for Inspection Date June 28, 2000

247. Notice of CT DEP Air Inspection, dated March 26, 2004

248. Pre-Inspection Questionnaire (PIQ) for Calendar Year 2003

249. Letter, dated May 7, 2010, from GZA to Saint Mary's Hospital Re: Results of Greenhouse Gas Emissions Evaluation

250. Registration/Application to Seek Coverage Under the General Permit to Limit Potential to Emit for Saint Mary's Hospital, dated March 2006

251. Approval of Registration for General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution, Effective Date June 15, 2006

252. CT DEP General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution, issued November 19, 2010

253. 2009 Annual Compliance Certification Form for CT DEP General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution

254. Letter from GZA, dated January 20, 2011, re: 2010 GPLPE Annual Compliance Certification

255. Letter from CTDEP, dated January 8, 2008, re: notice of plant inspection on March 12, 2008

256. Indoor Air Quality Survey, dated May 6, 2009, for Lawlor Building

257. Environmental Testing at Saint Mary's Hospital re: Air Change Rates/Indoor Air Quality, dated February 2007, prepared by Praxair

258. Formaldehyde Vapor Analysis Reports, dated April 16, 2008, prepared by Praxair

259. Air Change Rate Report, dated May 1, 2009, prepared by Praxair

260. Acetic Acid & Hydrogen Peroxide lab Results Report, monitoring date May 26, 2009, prepared by Praxair

261. Fume Hood Environmental Monitoring Report, dated March 22, 2006, prepared by Praxair

262. Environmental Monitoring at Saint Mary's Hospital re: Air Change Rates, Indoor Air Quality, and Microbiological/Mold, dated March 2008, prepared by Praxair

263. Environmental Monitoring for Saint Mary's Child Development Center re: Air Change Rates and Indoor Air Quality, dated November 2007, prepared by Praxair

264. Environmental Monitoring for Saint Mary's Hospital re: Air Change Rates and Indoor Air Quality, dated January and February 2008, prepared by Praxair

265. Fume Hood Environmental Monitoring Report, dated May 1, 2009, prepared by Praxair

266. Fume Hood Environmental Monitoring Report, dated November 2, 2009, prepared by Praxair

267. Air Change Rate Report, dated November 2, 2009, prepared by Praxair

268. Air Change Rate Report, dated March 22, 2006, prepared by Praxair

269. Environmental Monitoring Report for Fume Hood, dated June 2010, prepared by Praxair

270. 2008 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

271. 2006 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

272. Boiler Operating Certificates 1995-2010

273. State of Connecticut DEP-Air Management Bureau-Hartford Premise Evaluation Report for inspection date April 26, 2004

274. 2005 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

275. 2004 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

276. 2003 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

277. 2002 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

278. 2001 Annual Compliance Certification Form to General Permit to Limit Potential to Emit from Major Stationary Sources of Air Pollution for Major Stationary Sources of Air Pollution

279. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 2000

280. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 1999

281. General Permit to Limit Potential to Emit Annual Emissions Summary for Reporting Year 1998

282. Letter from the City of Waterbury, dated January 23, 2001, re: cross connection inspection

283. Letter from the City of Waterbury, dated January 18, 2001, re: test results from November 28, 2000 backflow prevention test

284. Letter from the City of Waterbury, dated January 5, 2000, re: test results from November 29, 1999 backflow prevention test

285. Letter from the City of Waterbury, dated June 22, 1998, re: test results from May 19, 1998 backflow prevention test

286. Letter from the City of Waterbury, dated January 7, 1998, re: test results from the reduced pressure backflow preventer testing on November 26 and 28, 1997

287. Letter from the City of Waterbury, dated March 26, 1997, re: test report from backflow prevention testing on March 26, 1997

288. Letter from the City of Waterbury, dated January 14, 1997, re: test results from November 29, 1996 backflow prevention test

289. Letter from the City of Waterbury, dated January 22, 1996, re: test results from November 24 and 26, 1995 backflow prevention tests

290. Letter from the City of Waterbury, dated January 22, 1996, re: violations detected during November 26, 1995 backflow prevention test

291. Letter from the City of Waterbury, dated January 31, 1996, re: compliance confirmed during reinspection conducted on November 24 and 25, 1995

292. Registration Form for Reauthorization Under the Domestic Sewage General Permit

293. Minor Photographic Processing General Permit for the Hospital (Certificate of Registration; General Permit Application No. 200700007; and Certification Form GPH2)

294. Minor Photographic Processing General Permit for the Dental Clinic (Certificate of Registration; General Permit Application No. 200700005; and Certification Form GPH2)

295. Minor Photographic Processing General Permit for the Naugatuck Walk-in Center (DEP Approval Letter, dated January 31, 2007; General Permit; General Permit Application No. 200700008; and Certification Form GPH2)

296. Minor Photographic Processing General Permit for Franklin Surgical Site (DEP Approval Letter, dated January 31, 2007; General Permit; General Permit Application No. 200700006; and Certification Form GPH2)

297. Letter, dated March 9, 2007, from GZA to City of Waterbury Water Pollution Control re: Minor Photographic Processing Wastewater Discharge at Saint Mary's Hospital

298. 1996 Industrial/Commercial Sewer Use Certification Statements for Saint Mary's Hospital and its related properties

299. 1995 Sewer User Certification Statement for Saint Mary's Hospital

300. Materials License, No. 06-00679-01, dated April 24, 2007, issued by the U.S. Nuclear Regulatory Commission (as amended by Amendment No. 55)

301. Ionizing Radiation Registration, dated December 30, 2009; Submitted to the CT DEP on January 1, 2010

302. Saint Mary's Hazardous Waste Disposal (Radioactive) Policy, revised April 2006

303. Saint Mary's Radioactive Contaminated Objects Waste Disposal Policy, dated December 2010

304. Hazardous Substance Certificate and Indemnification Agreement, dated June 28, 1991

305. Phase II Subsurface Investigations Report, 51 North Elm Street, Waterbury, Connecticut, dated July 26, 2007, prepared by HRP Associates, Inc.

306. Subsurface Investigation Report, dated January 11, 2008, prepared by GeoInsight for 51 North Elm Street, Waterbury, Connecticut

307. Memorandum, dated January 14, 2008, prepared by GeoInsight re: break down of the estimated remediation costs for 51 North Elm Street, Waterbury, Connecticut

308. Letter, dated February 1, 2008, from GeoInsight re: proposal for subsurface remedial investigation, design, and implementation services for 51 North Elm Street, Waterbury, Connecticut

309. Escrow and Release Agreement, dated February 11, 2008, for 51 North Elm Street, Waterbury, Connecticut

310. Memorandum, dated February 14, 2008, from GeoInsight re: Proposed Work Schedule for 51 North Elm Street, Waterbury, Connecticut

311. HRP Associates, Inc.'s Proposal for Oversight of the Environmental Remediation That Has Been Proposed by GeoInsight for 51 North Elm Street, Waterbury, Connecticut, dated March 18, 2008

312. HRP Invoice, dated October 9, 2008, for Project Management Services

313. E-mail, dated February 27, 2009, from HRP Associates, Inc. re: completion of soil remediation at 51 North Elm Street, Waterbury, Connecticut

314. Memorandum, dated March 20, 2009, from GeoInsight re: Pavement Restoration and Compliance/Post Remedial Ground Water Monitoring at 51 North Elm Street, Waterbury, Connecticut

315. E-mails, dated May 13, 2010, May 21, 2010, and May 24, 2010 re: partial disbursement of environmental escrow and retention of $25,000 for 51 North Elm Street, Waterbury, Connecticut

316. Letter, dated June 23, 2010, enclosing a check representing the agreed amount of the environmental escrow release for 51 North Elm Street

317. Payment Notice, dated October 7, 2010, re: GeoInsight invoices for environmental remediation services at 51 North Elm Street, Waterbury, Connecticut

318. E-mail, dated December 22, 2010, from GeoInsight re: 51 North Elm Street-Status of Ground Water Monitoring

319. Saint Mary's Preliminary Mold Inspection of Slocum and Xavier 5, dated January 26, 2006

320. Saint Mary's Preliminary Mold Inspection of Kenny 3, dated September 12, 2006

321. Saint Mary's Preliminary Mold Inspection of Sacred Heart Basement, dated September 14, 2006

322. Mold Environmental Monitoring Report, dated October 15, 2007, prepared by Praxair

323. Mold and Fungi Inspection Report, dated June 4, 2010, prepared by Superior Industries L.L.C.

324. Certificate of Mold Analysis, dated February 10, 2010, prepared by Pro Lab

325. Mold and Fungi Inspection Report, dated July 25, 2008, prepared by Superior Industries L.L.C.

326. Certificates of Mold Analysis, dated July 7, 2008, prepared by Pro-Lab

327. Mold and Fungi Remediation Recommendation Report, dated January 21, 2009, prepared by Superior Industries L.L.C.

328. Mold and Fungi Remediation Recommendation Report, dated May 20, 2009, prepared by Superior Industries L.L.C.

329. Mold and Fungi Inspection Report, dated September 20, 2010, prepared by Superior Industries L.L.C.

330. Certificates of Mold Analysis and Mold Analysis Reports for Pediatric Ward, dated June 25, 2008, prepared by Pro-Lab

331. Lead Analysis Report, dated April 6, 2007, for Drinking Water Child Care Area

332. Raydon and Lead Testing Recommendation Report, dated February 20, 2009, re: Children's Day Care Center

333. Environmental Monitoring at Saint Mary's Hospital, dated September 2006, prepared by Praxair

334. Environmental Monitoring at Saint Mary's Hospital, dated March 2007, prepared by Praxair

335. Environmental Monitoring Reports for anesthetic waste gas, air change rate, ethylene oxide, and fume hood, dated March 2010, prepared by Praxair

336. Laboratory Report – Full Particle Identification for Saint Mary's Hospital Lobby, dated February 5, 2008, prepared by EMSL Analytical, Inc.

337. Fire Marshall Inspection Certificates/Reports for 1994-2010

338. Policyholder Environment of Care Review and Risk Improvement Report, dated February 23, 2010, prepared by Zurich Services Corp.

339. Policyholder Environment of Care Review and Risk Improvement Report, dated April 21, 2009

340. Policyholder Environment of Care Review and Risk Improvement Report, dated May 13, 2008

341. Policyholder Environment of Care Review and Risk Improvement Report, dated May 8, 2007

342. Utilities Management Program for Plant Operations Department

343. Saint Mary's Hospital Environmental Compliance Assistance (internal guidelines)

344. Contract of Sale between Saint Mary's Hospital Corporation and Tom Gessler for Parcel 10B, Abbott Terrace in Waterbury, Connecticut (undated)

345. Phase I Environmental Site Assessment of Saint Mary's Hospital & Adjacent Facilities, dated February 26, 2011, prepared by Environmental Risk Services, LLC (including all Appendices)

346. Letter, dated February 24, 2011, from Environmental Risk Services, LLC to Gobbell Hays Partners, Inc. re: Environmental Summary Report for 290 French Street, Watertown, CT

347. Hazardous Materials Survey Report, dated August 10, 2011, prepared by HRP Associates, Inc.

348. Limited Asbestos—Containing Materials Survey Report, SMRI

349. Sacred Heart Cafeteria Serving Area, dated September 27, 2011, prepared by HRP Associates, Inc.

350. Environmental Reviewed and Phase II Subsurface Investigations Report, dated June 28. 2011, prepared by HRP Associates, Inc.

351. Phase III Subsurface Investigations Report, dated September 28. 2011, prepared by HRP Associates, Inc. (attached as Phase III)

352. Additional Phase III Subsurface Investigations Report, dated March 2, 2012, prepared by HRP Associates, Inc. (attached as 2012 Final Additional Phase III Report)

353. Closure Report for Former Less Than 180 Day Hazardous Waste Container Storage Area, dated July 17, 2012, prepared by HRP Associates, Inc. (attached as 2012 Final Closure Report)

354. Hazardous Materials Survey Report, dated October 4, 2011, prepared by HRP Associates, Inc.

355. Phase I Environmental Site Assessment Report, dated October 4, 2011, prepared by HRP Associates, Inc.

356. Limited Ground Penetrating Radar (GPR) Survey Report, dated October 11, 2011, prepared by HRP Associates, Inc.

357. 2013 General Permit to Limit Potential to Emit - Annual Compliance Certification Form, dated March 20, 2014

358. 2014 General Permit to Limit Potential to Emit - Emissions Calculator for 2014 Calendar Year, dated February 2015

359. 2013 Tier2 Chemical Inventory Report, dated March 26, 2014

360. 2014 Tier2 Chemical Inventory Report, dated February 18, 2015

**Schedule 6.22**

**Employee Benefit Matters**

6.22(a)

1. Paid Time Off (used for vacation, holiday, personal, and sick time)
2. Bereavement Leave
3. Jury Duty Leave
4. Military Duty Leave
5. Pregnancy Leave
6. Donated Time
7. Employee Assistance Plan
8. Health Plan (self-insured)
9. Dental Plan (self-insured)
10. Basic Life Insurance
11. Supplemental Life Insurance
12. Dependent Life Insurance for spouse and/or dependent(s)
13. Short Term Disability
14. Long Term Disability
15. Basic Accidental Death & Dismemberment
16. Voluntary Accidental Death & Dismemberment
17. Discounted YMCA membership
18. Saint Mary's Hospital Retirement Savings Plan
19. Pension Plan for Employees of St. Mary's Hospital Corporation
20. Home & Auto Insurance (paid through payroll deduction)
21. On-site Parking (paid through payroll deduction)
22. Health Care Professional Liability Insurance
23. Excess Medical Professional Liability Insurance

24. Annual License Renewal

25. Flexible Spending Account
    a. Medical
    b. Dependent Care

26. Tuition Reimbursement

27. Amended and Restated Saint Mary's Hospital, Inc. 457(b) Deferred Compensation Plan

28. Amended and Restated Saint Mary's Hospital, Inc. 457(f) Supplemental Deferred Compensation Plan

29. Second Amended and Restated Employment Agreement by and between Saint Mary's Hospital, Inc. and Chad Wable, dated January 31, 2013

30. Non-Competition and Severance Agreement for Executive by and between Saint Mary's Hospital, Inc. and Steven Schneider, M.D., dated May 25, 2011

31. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Michael Novak, dated June 20, 2008, as amended

32. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Ralph W. Becker, dated January 27, 2014

33. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital, Inc. and Charles M. Flinn, dated December 12, 2013

34. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and James B. Tucker, dated August 8, 2013

35. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital, Inc. and Clark Kearney, dated June 24, 2008, as amended

36. Amended and Restated Non-Competition and Severance Agreement for a Director by and between Saint Mary's Hospital, Inc. and Joseph Connolly, dated July 3, 2008, as amended

37. Retiree medical (self-insured)

38. Retiree life insurance

39. Executive Incentive Plans

To the knowledge of Saint Mary's, all documents required to be disclosed pursuant to the second paragraph of 6.22(a) have been provided to Trinity Health.

<u>6.22(b)</u>

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

A submission under the IRS's VCP was filed for each of the 401(k) Plan and Pension Plan with the most recent IRS determination letter submission for the plan to correct untimely amendments. A Compliance Statement from the IRS in connection with the VCP submission for the 401(k) Plan was issued on September 14, 2011. A Compliance Statement from the IRS in connection with the VCP submission for the Pension Plan was issued on July 25, 2011.

6.22(c)

None, provided the church plan exemption as described in Schedule 6.07 is legally valid and in effect for the Pension Plan for Employees of St. Mary's Hospital Corporation.

6.22(d)

None.

6.22(e)

The following St. Mary's Benefit Plans are intended to be "church plans:"

St. Mary's Hospital Retirement Savings Plan

Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan")

All health and welfare plans

The Pension Plan's funded status is materially below the 80% standard set forth in the Agreement section 6.22(e), and for which an Agreement Disclosure Schedule exception is now taken.

6.22(f)

All Saint Mary's welfare benefit plans have been considered and treated as exempt Church Plans.

Saint Mary's provides retiree medical and life insurance benefits.

6.22(g)

1. Amended and Restated Non-Competition and Severance Agreement, as amended, by and between Saint Mary's Hospital, Inc. and Joseph Connolly, dated July 3, 2008
2. Amended and Restated Non-Competition and Severance Agreement for a Vice President, as amended, by and between Saint Mary's Hospital, Inc. and Clark Kearney, dated June 24, 2008
3. Amended and Restated Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and Michael Novak, dated June 20, 2008
4. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital and Steven Schneider, M.D., dated May 25, 2011
5. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and Ralph W. Becker, dated January 27, 2014
6. Non-Competition and Severance Agreement for an Executive by and between Saint Mary's Hospital and Charles M. Flinn, dated December 12, 2013
7. Non-Competition and Severance Agreement for a Vice President by and between Saint Mary's Hospital and James B. Tucker, dated August 8, 2013
8. Second Amended and Restated Employment Agreement by and between Saint Mary's Hospital, Inc. and Chad Wable, dated January 31, 2013
9. Amended and Restated Saint Mary's Hospital, Inc. 457(b) Deferred Compensation Plan and Amended and Restated Saint Mary's Hospital, Inc. 457(f) Supplemental Deferred Compensation Plans
10. Executive Incentive Plans

6.22(h)

Church Plan Exemption: The Internal Revenue Service issued a Private Letter Ruling ("PLR") to Saint Mary's Hospital Corporation dated March 18, 1993, in which it concluded that the Pension Plan for Employees of St. Mary's Hospital Corporation ("Pension Plan") was a church plan within the meaning of Internal Revenue Code ("Code") Section 414(e). No irrevocable and affirmative election has previously been made pursuant to Code Section 410(d) to make such otherwise exempt church plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and to the additional plan qualification requirements set forth in Treasury Regulations Section 1.401(d)-1 and in other related Code provisions. However, a request for a Department of Labor opinion that the Pension Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Pension Plan is determined to be subject to ERISA, it would result in significant liability.

Effective in 1997 Saint Mary's established a defined contribution retirement plan for its eligible participants, which is known as the St. Mary's Hospital Retirement Savings Plan ("Savings Plan"), and which contains a Code Section 401(k) component. Although the Savings Plan has been operated as a church plan that is exempt from Title I of ERISA, a request for an IRS PLR that the Savings Plan is a church plan within the meaning of Code Section 414(e) has not be

requested. In addition, a request for a Department of Labor opinion that the Savings Plan is a church plan within the meaning of ERISA Section 3(33) has not been requested. If the Savings Plan is determined to be subject to ERISA, it could likely result in a significant liability.

6.22(k)

None.

**Schedule 6.23**

**Employment Matters**

None.

**Schedule 6.24**

**Taxes**

1. Failed to file 2009 Form 990 for the Heart Center of Greater Waterbury, Inc.

2. Saint Mary's Hospital was audited by the State of Connecticut for Sales and Use Tax in early 2010 for the calendar years from 12/31/2004 to 12/312009. The Hospital did not remit sales tax collected on certain contract revenues. The audit resulted in a tax of $7,159.86 with penalties and interest of $3,406.15 for a total of $10,566.01. Such tax was paid in full. The Hospital now files those tax returns every year and remits to the State

**Schedule 6.25**

**Insurance**

**Complete List of Current Insurance/Self-Insurance Policies**

1. Workers Compensation and Employers Liability Insurance Policy - Pennsylvania Manufacturers Indemnity Company

2. For all additional policies, see attached.

**Pending Claims and Claims History for 10 Year Period Prior to Signing Date**

See Attachment to Schedule 6.25

# Saint Mary's Health System, Inc.

Summary of Insurance Effective as of July 1, 2015
People's United Insurance Agency

| Company | Policy Number | Policy Period | Annual Premium |
|---|---|---|---|
| American Guarantee & Liability Ins Co. (Zurich) | ZMD353933914 | 10/01/14-15 | $191,805 (Includes $3,000 Engineering Fee) |

## PROPERTY

| Coverage | Limit | Deductible |
|---|---|---|
| Blanket Building & Business Personal Property | | |
| 56 Franklin St Campus & Other Locations per Statement of Values | $375,000,000 | $25,000 |
| Business Interruption | Included | |
| Extra Expense | 25,000,000 | |
| Machinery Breakdown | 150,000,000 | 25,000 |
| Earthquake | 100,000,000 | 50,000 |
| Flood | 100,000,000 | 50,000 |

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| | | | |
|---|---|---|---|
| American Guarantee & Liability Ins Co | BAP932700901 | 10/01/14-15 | $16,330 |

## AUTOMOBILE

| Limits | |
|---|---|
| Bodily Injury & Property Damage Limit (Incl. Hired & Non Owned) | $1,000,000 |
| Medical Payments | $5,000 |
| Uninsured & Underinsured Motorist (Conversion) | $1,000,000 |
| Comprehensive Deductible (full glass) | $500 |
| Collision Deductible | $1,000 |

**Additional Coverage and Exclusions**

| | |
|---|---|
| Rental Reimbursement | $30 Day/$900 Max |
| Primary Hired Auto Physical Damage | $50,000 |
| Commercial Auto Extension Endorsement | Included |
| Ambulance and/or Emergency Vehicles | Excluded |

**GARAGE KEEPERS – DIRECT PRIMARY**

**Locations:**

1. 56 Franklin Street, Waterbury, CT
2. 88 Union Street, Waterbury, CT
3. 133 Scovill Street, Waterbury, CT
4. 100 Union Street, Waterbury, CT
5. 353 East Main Street, Waterbury, CT

**Garagekeepers Limit – Each Location**

$75,000 Comprehensive ($500 deductible/$2,500 max)
$75,000 Collision ($500 deductible)

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| | | | |
|---|---|---|---|
| Global Aerospace, Inc. | 10041881 | 10/01/14-15 | $14,025 |

**HELIPORT LIABILITY**

**Limits**

| | |
|---|---|
| $10,000,000 | Each Occurrence |
| $ 25,000 | Fire Damage Limit (Any One Fire) |
| $ 10,000 | Medical Expense (Any One Person) |
| $10,000,000 | Non Owned Aircraft Liability |

| | | | |
|---|---|---|---|
| ProSelect Insurance Company | PSCCA10201402 | 10/01/14-15 | $935,000 |

**EXCESS LIABILITY**

Reinsured: - Saint Mary's Indemnity Company LLC

**Limits**

| | |
|---|---|
| $15,000,000 | Health Care Professional Liability - Specific Loss Limit |
| $15,000,000 | Health Care Professional Liability - Aggregate Limit |
| $25,000,000 | Other Coverage (GL) – Specific Loss Limit |
| $25,000,000 | Other Coverage (GL) - Aggregate Limit |

**Underlying Limits**

| | |
|---|---|
| $3,000,000/$14,000,000 | Professional Liability (Claims-Made) |
| $1,000,000/$4,000,000 | General Liability (Occurrence) |
| $1,000,000/$1,000,000 | Employee Benefits Liability |
| $1,000,000 | Automobile Liability |
| $1,000,000/$1,000,000/$1,000,000 | Employers Liability |
| $10,000,000 | Helipad Liability |
| $1,000,000/$2,000,000 | Child Development Center General Liability (Occurrence) |

| | | | |
|---|---|---|---|
| Allied World Assurance Company | 03086025 | 10/01/14-15 | $50,000 |

**Excess Liability**

**Limits** $5,000,000 XS $15,000,000 Health Care Professional Liability

National Union Fire Insurance Co. of Pittsburgh PA 015933607 10/01/14-15 $110,630

**DIRECTORS & OFFICERS LIABILITY/EMPLOYMENT PRACTICES LIABILITY (CLAIMS-MADE)**

**Limits**

| | | |
|---|---|---|
| | $15,000,000 | Each Claim or related Claims and in the policy aggregate (inclusive of defense expenses) |
| | $500,000 | EMTALA |
| | $500,000 | HIPAA |

**Retentions**

| | |
|---|---|
| $ 0 | Insured Persons |
| $250,000 | Corporate Indemnification & Insured Entity |
| $350,000 | Anti-Trust with 75/25 Coinsurance |
| $200,000 | Employment Practices Liability & Third Party EPL |

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Allied World National Assurance Company 03059844 10/01/14-15 $20,790

**DIRECTORS & OFFICERS SIDE A LIABILITY (CLAIMS-MADE)**

**Limits** $5,000,000 excess $15,000,000 National Union Fire

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Illinois National Insurance Company 02-778-21-50 1/30/15-16 $27,286

**FIDUCIARY LIABILITY** $5,000,000 Limit

**DEDUCTIBLE** $25,000

Travelers Casualty & Surety Co. of America 105686950 10/01/14-15 $17,150

**CRIME**

| | | |
|---|---|---|
| **Limits** | $5,000,000 | Employee Theft |
| | $5,000,000 | ERISA |
| | $5,000,000 | Forgery or Alteration |
| | $5,000,000 | On Premises |
| | $5,000,000 | In Transit |
| | $5,000,000 | Money Orders & Counterfeit Money |
| | $5,000,000 | Computer Fraud |
| | $100,000 | Computer Program & Electronic Data Restoration Expense |
| | $5,000,000 | Funds Transfer Fraud |
| | $10,000 | Theft of Client Property |
| | $10,000 | Theft of Patient Property |
| | $1,000,000 | Personal Accounts Forgery or Alteration |
| | $10,000 | Claim Expense |
| **DEDUCTIBLES** | | |
| | $ 50,000 | |
| | $ 0 | ERISA & Claim Expense |
| | $ 500 | Theft of Client & Patient Property |
| | $ 1,000 | Computer Program & Electronic Data Restoration Expense |
| **KIDNAP & RANSOM** | | |
| | $5,000,000 | Kidnap for Ransom |
| | $5,000,000 | Extortion for Ransom |
| **IDENTITY FRAUD EXPENSE** | | |
| | $ 25,000 | Limit |

| | | | |
|---|---|---|---|
| Beazley/Lloyd's | W104CB150601 | 1/01/15-16 | $49,400<br>Includes Tax |

**NETWORK SECURITY/BREACH RESPONSE "CLAIMS MADE"**

| | | |
|---|---|---|
| Limits: | $3,000,000 | Per Claim and in the Aggregate, inclusive of: |
| | 3,000,000 | Information Security and Privacy Liability |
| | 3,000,000 | Website Content Liability |
| | 1,500,000 | Regulatory Action Defense & Penalties |
| | 3,000,000 | Security Event Data Restoration |
| | 3,000,000 | Cyber Extortion |
| | 2,500,000 | Aggregate Limit for all Computer Expert Services, Legal Services and Public Relations and Crisis Management Expenses |
| | 250,000 | PCI Fines & Penalty Coverage |
| Retention: | $ 50,000 | Per Claim |

Includes: Privacy Breach Response Services, subject to $10,000 Retention each breach:
Notification of up to 2 Million Individuals
Credit Monitoring for breaches with obligation to notify 100 or more individuals

| | | | |
|---|---|---|---|
| Ironshore Specialty Insurance Company (3 Yrs) | 000970501 | 10/01/12–15 | $48,338 est.<br>Includes Tax |

**POLLUTION LEGAL LIABILITY**

| | | |
|---|---|---|
| Limits: | $3,000,000 | Third Party Claims for Bodily Injury, Property Damage and Remediation Expenses |
| | $3,000,000 | First Party Remediation Expenses |
| | $3,000,000 | Emergency Response Expenses |
| | $3,000,000 | Business Interruption, 365 Days |
| | $3,000,000 | Disinfection Event Expenses |
| | $3,000,000 | Evacuation Expenses |
| Deductibles: | $25,000 | Each Incident |
| | 5 Days | Business Interruption |

| | | | |
|---|---|---|---|
| Ace American Insurance Company | G24796012001 | 10/01/14-15 | $1,547 |

**STORAGE TANK LIABILITY – Financial Responsibility**

| | | |
|---|---|---|
| Limits: | $1,000,000 | Per Storage Tank Incident – Claims & Remediation Costs |
| | $1,000,000 | Aggregate – Claims & Remediation Costs |
| | $1,000,000 | Aggregate Limit for all Legal Defense Expenses |
| | $2,000,000 | Total Policy Aggregate |
| Deductible: | $5,000 | Per Incident |

| | | | |
|---|---|---|---|
| The Travelers Indemnity Company of CT | 6607D013207 | 10/01/14-15 | $2,882 |

**GENERAL LIABILITY – CHILD DEVELOPMENT CENTER**

**General Liability Limit**

| | |
|---|---|
| $2,000,000 | Aggregate |
| 2,000,000 | Products/Completed Operations Aggregate |
| 1,000,000 | Personal & Advertising Injury |
| 1,000,000 | Each Occurrence |
| 300,000 | Damage to Premises Rented to You |
| 5,000 | Medical Expense (excludes children in daycare program) |

**Abuse/Molestation Limit**

| | |
|---|---|
| 2,000,000 | Aggregate |
| 1,000,000 | Each Abuse or Molestation Offense |

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| | | | |
|---|---|---|---|
| Hartford Life and Accident Insurance Company | 02SR365272 | 10/01/14-15 | $340 |

**SPECIAL RISK ACCIDENT – CHILD DEVELOPMENT CENTER**

**Limits:**

| | |
|---|---|
| $ 5,000 | Accidental Death Benefit |
| 10,000 | Accidental Dismemberment Benefit |
| 35,000 | Catastrophe Benefit |
| 25,000 | Accident Medical Expense Benefit |
| 1,000 | Dental Limit |

**Schedule 7.04**

**Conflicts - Trinity Health and NE-RHM**

Consents, approvals, Permits, Governmental Orders, declaration and filings with, or notices to the following Governmental Authorities may be required by or with respect to Trinity Health and NE-RHM in connection with the execution and delivery of the Agreement and the other Transaction Documents and the consummation of the transactions contemplated hereby and thereby:

Roman Catholic Archdiocese of Hartford
Holy See, Roman Catholic Church
State of Connecticut Office of HealthCare Access
Office of the Attorney General of the State of Connecticut
Federal Trade Commission

**Schedule 7.08(a)**

**Compliance with Laws - NE-RHM**

On August 24, 2015, the State of Connecticut Department of Social Services, Office of Quality Assurance, Audit Division ("DSS") sent a letter to Saint Francis Hospital and Medical Center ("SFHMC") with findings of a claim review with dates of service July 1, 2011 through June 30, 2014 in which co-insurance or deductibles were paid to SFHMC. According to the letter the payment due DSS is $993,559. The letter was incorrectly addressed and was not delivered to SFHMC until September 8, 2015. SFHMC is reviewing the letter and expects to appeal.

**Schedule 7.09(a)**

**Medicare - Plans of Correction - NE-RHM**

Saint Francis Hospital and Medical Center had its tri-annual Joint Commission survey on October 21-24, 2014. We are in process of submitting corrective action plans which are due by December 20, 2014 and January 4, 2014. A follow-up visit occurred on December 4, 2014 to validate compliance with certain Conditions of Participation and the Joint Commission concluded Saint Francis Hospital and Medical Center was in compliance. A follow up visit was conducted by the Joint Commission on June 22-23, 2015. Full compliance with all standards was identified with no further actions required.

The Department of Public conducted a CMS validation survey beginning November 24, 2014. The Department of Public Health identified Saint Francis Hospital and Medical Center was in full CMS compliance.

Mount Sinai Rehabilitation Hospital had its tri-annual Joint Commission survey on December 1st and 2nd of 2014. The report has been received, full compliance with CMS standards was identified and the evidence of Joint Commission standards compliance was submitted by the due dates of January 16, 2015 (45 day plan) and January 31, 2015 (60 day plan). Full compliance with Joint Commission standards was identified by the Joint Commission with acceptance of completed plans and data metrics on June 2, 2015.

**Schedule 7.09(b)**

**Medicare/Medicaid Claims - NE-RHM**

None.

**Schedule 7.12**

**HIPAA - Breach Notifications - NE-RHM**

| Date of Occurrence | Description | Status |
|---|---|---|
| 11/10/2014 | Theft of camera at Access Center | A breach notification has not yet been made regarding this occurrence, as Saint Francis is still completing its internal investigation. Incident reported in the 2015 Annual Report to OCR. |
| 10/24/2014 | Inappropriate Access to PHI | Saint Francis has not received any correspondence from the Office of Civil Rights regarding this occurrence. Incident reported in the 2015 Annual Report to OCR. |
| 9/23/2014 | Stolen Laptop | Saint Francis has not received any correspondence from the Office of Civil Rights regarding this occurrence. Incident reported in the 2015 Annual Report to OCR. |
| 12/27/2013 | Paper records with certain patient information stolen from physician's vehicle | There have been two requests for information from the Office of Civil Rights regarding this occurrence and Saint Francis has responded to both requests. OCR has closed this matter. Refer to 6.14(a). |

**Schedule 8.08(a)**

**Insured Real Property**

1. **Parcel One**

That certain piece or parcel of land situated on the southerly side of Scovill Street, the westerly side of Franklin Street, the northerly side of Union Street and the easterly side of South Elm Street in the City of Waterbury, Conn. bounded and described as follows:

Beginning at an iron pin marking the intersection of the southerly line of Scovill Street with the easterly line of South Elm Street, said point being the northwesterly corner of the within described land, thence running in the southerly line of Scovill Street, S 77° 39' 30" E 304.17 feet to a point of curve marked by a drill hole, thence running southeasterly and in a line curving to the right having a radius of 50.285 feet, a central angle of 66° 19' 38"1, a distance of 58.21 feet to a point of compound curve marked by a drill hole, thence running southerly and in a line curving to the right having a radius of 147.42 feet, a central angle of 22° 13' 12", a distance of 57.17 feet to Franklin Street and a point of tangency marked by a drill hole, thence running in the westerly line of Franklin Street S 10° 53' 20" W 320.80 feet to Union Street, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 60.00 feet a distance of 30.95 feet to a point of tangency, the last two described points being connected by a chord having a bearing of S 86° 26' 23" W 30.61 feet, thence running in the northerly line of Union Street N 78° 45' 10" W 223.04 feet to a point of curve marked by a drill hole, thence running westerly in the northerly line of Union Street and in a line curving to the right having a radius of 393.00 feet, a central angle of 14° 30' 02", a distance of 99.46 feet to a point of compound curve marked by a drill hole, thence running northwesterly in a line curving to the right having a radius of 27.56 feet, a central angle of 76° 50' 58", a distance of 37.02 feet to South Elm Street, and a point of tangency, said point being marked by a drill hole, thence running in the easterly line of South Elm Street N 12° 34' 50" E 381.36 feet to Scovill Street and the point of beginning. Said parcel containing 151,285 square feet.

BOUNDED:

NORTHERLY: By Scovill Street

NORTHEASTERLY: by a curved line that connects the southerly line of Scovill Street with the westerly line of Franklin Street
EASTERLY: By Franklin Street

SOUTHERLY: By Union Street

SOUTHWESTERLY: by a curved line that connects the northerly line of Union Street with the easterly line of South Elm Street.
WESTERLY: by South Elm Street.

Being the premises shown on a certain map entitled: "AS-BUILT SURVEY MAP OF LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. JAN. 30, 1980 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 14, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Town Clerk.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C. Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40' " to be filed in the office of the Waterbury Town Clerk.

**2. <u>Parcel Two</u>**

That certain piece of parcel of land situated on the easterly side of South Elm Street, the northerly side of Scovill Street and the southwesterly side of Cole Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin marking the intersection of the easterly line of South Elm Street with the northerly line of Scovill Street, said point being the southwesterly corner of the within described land, thence running in the easterly line of South Elm Street N 11° 43' 24" E 284.60 feet to a point of curve, thence running easterly in a curved line having a radius of 9.70 feet, a central angle of 128° 16', that connects the easterly line of South Elm Street with the southwesterly line of Cole Street, and in a line curving to the right having a distance of 21.72 feet to Cole Street and a point of tangency, thence running in the southwesterly line of Cole Street and tangent to the curve S 40° 00' 36" E 148.72 feet to land now or formerly of Saint Mary's Hospital Corporation, thence running in line of land now or formerly of Saint Mary's Hospital S 11° 43' 24" W, 141.04 feet, S 78° 16' 36" E, 30.29 feet, S 11° 43' 24", 49.70 feet, N 78° 21' 24" W 12.94 feet, N 33° 19' 09" W 8.485 feet, N 77° 58' 50" W 5.85 feet and S 11" 40' W 16.00 feet to Scovill Street, thence running in the northerly line of Scovill Street N 78° 01' 09" W 137.98 feet to South Elm Street and the point of beginning.

BOUNDED:

NORTHERLY: by a curved line that connects the easterly line of South Elm Street with the southwesterly line of Cole Street and by land now or formerly of Saint Mary's Hospital Corporation.

NORTHEASTERLY: by Cole Street.

EASTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHERLY: by Scovill Street and by land now or formerly of Saint Mary's Hospital Corporation.

SOUTHWESTERLY: by land now or formerly of Saint Mary's Hospital Corporation.

WESTERLY: by South Elm Street.

Being the premises shown on a map entitled "MAP SHOWING PARCEL #1 LAND OF SAINT MARY'S HOSPITAL CORPORATION WATERBURY, CONN. THE A.J. PATTON CO. SURVEYOR, WATERBURY, CONN. DEC. 28, 1979 SCALE 1" = 20' REVISED MARCH 10, 1980, REVISED JUNE 10, 1983, REVISED FEB. 27, 1984, REVISED AUG. 25, 1988" to be filed in the office of the Waterbury Clerk.

Together with those easements, covenants, and rights reserved by the Grantor and in a Quit Claim Deed dated January 27, 1988 and recorded February 2, 1988 in Volume 2235, at Page 33 of the Waterbury Land Records and a Corrective Quit Claim Deed dated March 16, 1988 and recorded March 30, 1988 in Volume 2261, at Page 241 of the Waterbury Land Records, in which the Grantor granted to

The Slocum Corporation a certain parcel of land in the City of Waterbury, County of New Haven, State of Connecticut.

Together with those easements, covenants and rights-contained in an Easement Agreement dated September 26, 1988 between and among Saint Mary's Hospital Corporation, Scovill Street Medical Building Association, Inc., and The Slocum Corporation.

Together with those rights contained in a Release of Covenant to Subordinate dated September 26, 1988 between Saint Mary's Hospital Corporation and Scovill Street Medical Building Association, Inc. and recorded in Volume 2364, Page 90 of the Waterbury Land Records.

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

**3. <u>Parcel Three</u>**

Grantor's rights to an air space easement granted to Grantor by the City of Waterbury by Quit Claim Deed dated March 18, 1980 and recorded in Volume 1438 at Page 73 of the Waterbury Land Records, said easement being more particularly described as follows:

The air space beginning at a distance of fourteen feet above the said crown of Scovill Street and consisting of all the air space beginning at the said fourteen feet distance above the said crown of Scovill Street) above the following piece or parcel of land:

That certain piece or parcel of land being a portion of Scovill Street situated easterly of South Elm Street in the City of Waterbury, Connecticut bounded and described as follows:

Beginning at an iron pin set in the northerly line of Scovill Street, said pin being S 78° 01' 06" E 132.46 feet, from an iron pin that marks the intersection of the northerly line of Scovill Street with the easterly line of South Elm Street as measured in the northerly line of Scovill Street, thence running in the northerly line of Scovill Street S 78° 01' 06" E 80.00 feet, thence running across Scovill Street 11° 58' 54" W 39.99 feet to the southerly line of Scovill Street, thence running in the southerly line of Scovill Street N 77° 39' 30" W Or-' feet, thence running across Scovill Street N 11° 58' 54" E 39.49 feet to the northerly line of Scovill Street and the point of beginning.

**4. <u>Parcel Four</u>**

That parcel of land in the City of Waterbury, County of New Haven, State of Connecticut, shown on map entitled, "Topographic Survey, South Elm St. and Union St., Waterbury, Connecticut. Prepared for Saint Mary's Hospital" scale 1" = 20', dated 2/20/89, revised 4/17/89, last revision 10/9/89, prepared by Kasper Associates, which map is filed with the Town Clerk of Waterbury in Drawer XXVIII, Page 73 and such map has been further revised July 26, 1990, but such further revised map is not intended to be filed on the land records, and which parcel being triangular in shape is described as follows: beginning at a point in the easterly streetline of South Elm Street as shown on said map, said point also being the southwest corner of said parcel thence along the eastern streetline of South Elm Street N.12° 37' 14" E 209.79 feet; thence along a curve concave to the northwest with radius of 15.00 feet, arch length of 23.90 feet and delta of 91° 16' 32"; thence along the southerly street line of Union Street the following two

courses, S 76° 06' 14" E a distance of 413.54 feet and along a curve concave to the south with radius of 1225.00 feet, arc length of 99.17 feet and delta 04° 38' 19" to a C.H.D. monument N. 261898.9378, E 521693.2863, thence S 80° 55' 49" W along monumented highway line of interstate 84 a distance of 559.84 feet; thence S 48° 55' 48" W still along monumented highway line of Interstate 84 a distance of 13.00 feet to the point of beginning.

Said parcel contains 1.30 acres.

(Bounded by Interstate 84, South Elm Street and Union Street)

Together with such rights, if any, as acquired under an Encroachment Agreement by and between the State of Connecticut Department of Transportation and Saint Mary's Hospital Corporation, dated July 31, 1991 and recorded September 12, 1991 in Volume 2774 at Page 229 of the Waterbury Land Records, with respect to a pedestrian link between parcel 4 and parcel 1, as shown on plan entitled "Pedestrian Link Easement Map, Union Street, Waterbury, Connecticut, prepared for Saint Mary's Hospital KA, Kasper Associates, Engineers, Surveyors, Planners, Bethel, Connecticut, Scale 1" = 20', Date: 8/16/89 Sheet 1 of 1 designed by, drawn by, BEM check by JJK, Project No, 2348)

Being the same premises shown on a map entitled "Map of Properties owned by Saint Mary's Hospital Corporation, South Elm Street, Union Street and Scovill Street, Waterbury, Connecticut, Meyers Associates, P.C., Engineers, Surveyors, Planners, 60 Linden Street, Waterbury, Conn. 06702, April 29, 1997, Scale 1" = 40'" to be filed in the Office of the Waterbury Town Clerk.

**5. <u>Parcel Five</u>**

That certain parcel of land situated in the Town of Waterbury, County of New Haven and State of Connecticut, on the easterly side of Present Franklin Street, at Present Scovill Street, containing 0.77 of an acre, more or less, bounded and described as follows:

WESTERLY by Present Franklin Street, 303 fees, more or less, by a line designated "Release Line", as shown on the map hereinafter referred to;

WESTERLY,
NORTHWESTERLY
AND NORTHERLY by Present Franklin Street and by Present Scovill Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY by Present Scovill Street, 62 feet, more or less, by a line designated "Release Line", as shown on said map;

NORTHERLY,
NORTHEASTERLY
AND EASTERLY by Present Scovill Street and by Present Baldwin Street, each in part, 34 feet, more or less, by a line designated "Release Line", as shown on said map

EASTERLY by Present Baldwin Street, 299 feet, more or less, by a line designated "Release Line", as shown on said map;

SOUTHERLY by Present Union Street, 115 feet, more or less, by a line designated "Release Line", as shown on said map.

The above-described land comprises a portion of the premises acquired by the State of Connecticut from Saint Mary's Hospital Corporation as described in a Certificate of Condemnation recorded in Volume 1198 at Page 141 of the Waterbury Land Records; from the City of Waterbury as described in a Quit-Claim Deed recorded in Volume 1206 at Page 109 of said land records; and from Century Brass Products, Inc. as described in a Quit-Claim Deed recorded in Volume 1237 at Page 19 of said land records; and a portion of former Union Street, Baldwin Street and Cole Street.

**6. Parcel Six**

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running
S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

**7. Parcel Seven**

Office Condominium Unit 1A, 133 Scovill Street, Waterbury CT

**8. Parcel Eight**

Office Condominium Unit 2A, 133 Scovill Street, Waterbury CT

**9. Parcel Nine**

Office Condominium Unit 2B, 133 Scovill Street, Waterbury CT

**10. Parcel Ten**

Office Condominium Unit 2C, 133 Scovill Street, Waterbury CT

**11. Parcel Eleven**

Office Condominium Unit 2H, 133 Scovill Street, Waterbury CT

**12. Parcel Twelve**

Office Condominium Unit 2J, 133 Scovill Street, Waterbury CT

**13. Parcel Thirteen**

Office Condominium Unit 2K, 133 Scovill Street, Waterbury CT

**14. Parcel Fourteen**

Office Condominium Unit 3A, 133 Scovill Street, Waterbury CT

**15. Parcel Fifteen**

Office Condominium Unit 3B, 133 Scovill Street, Waterbury CT

**16. Parcel Sixteen**

Office Condominium Unit 3C, 133 Scovill Street, Waterbury CT

**17. Parcel Seventeen**

All that certain plot, piece or parcel of land, together with the improvements located thereon, situated, lying and being in the City of Waterbury, County of New Haven and State of Connecticut, being bounded and described as follows:

Beginning at the Westerly end of a curve connecting the Southerly side of Scovill Street and the Westerly side of South Elm Street;

Running thence in a general easterly direction, on a curve to the right having a radius of 8 feet for a distance of 12.64 feet to the Westerly side of South Elm Street;

Running thence along said Westerly side of South Elm Street, South 12 degrees 36' 46" West 345.35 feet to the Northerly end of a curve connecting said Westerly side of South Elm Street with the Northerly side of Union Street;

Running thence in a general Southwesterly direction on a curve to the right having a radius of 17.00 feet for a distance of 26.73 feet to the Northerly side of Union Street;

Running thence along said Northerly side of Union Street North 77 degrees 17' 05" West 246.85 feet to a point on lands now or formerly of Gulf Oil Corporation;

Running thence along the same, North 12 degrees 42' 55" East 137.39 feet to a point on lands now or formerly of Saint Mary's Hospital Corp.;

Running thence along the same the following courses and distances:

South 77 degrees 58' 14" East, 50.14 feet;
North 12 degrees 01' 46" East, 136.53 feet;
South 75 degrees 32' 14" East, 29.35 feet; and;
North 12 degrees 03' 46" East, 94.73 feet to the Southerly side of Scovill Street;

Running thence along said Southerly side of Scovill Street, South 77 degrees 56' 14" East, 178.40 feet to the point and place of beginning.

Together with and subject to all rights of way, easements and other right and obligation of the grantor appurtenant to the land, including all rights, title and interest of the grantor, if any, in and to the strips and gores, streets, highways and alleys abutting or adjacent thereto.

**18. Parcel Eighteen**

Those three certain pieces or parcels of land, with all the improvements thereon, situated in the City of Waterbury, County of New Haven and State of Connecticut, bounded and described as follows:

FIRST PIECE

That certain piece or parcel of land with all the improvements thereon, situated on the southwesterly corner of East Main Street and Mill Street in the City of Waterbury, County of New Haven and State of Connecticut know as #324-336 East Main Street, bounded and described as follows:

| | |
|---|---|
| NORTHERLY: | 79 feet on East Main Street |
| EASTERLY: | 136 feet on Second Piece; |
| SOUTHERLY: | on land now or formerly of The Church of the Immaculate Conception; and |
| WESTERLY: | 136 feet on land now or formerly of The Church of the Immaculate Conception. |

SECOND PIECE

A certain piece or parcel of land located on the southerly side of East Main Street, being portion of the discontinued Mill Street and is bounded and described as follows:

| | |
|---|---|
| NORTHERLY: | 28.00 feet, more or less, by East Main Street; |
| EASTERLY: | 130.00 feet, more or less, by land now or formerly of the State of Connecticut, acquired by the discontinuance of Mill Street; |
| SOUTHERLY: | 20.00 feet, by land of Century Brass Products, Inc., acquired by the discontinuance of Mill Street; and |
| WESTERLY: | 136.00 feet by land of Philip Avery. |

THIRD PIECE

That certain piece or parcel of land with all the improvements thereon situated in the City of Waterbury, County of New Haven and State of Connecticut, known as EAST MAN STREET, and more particularly bounded and described as follows:

| | |
|---|---|
| NORTHEASTERLY: | 19.86 feet by East Main Street; |
| SOUTHEASTERLY: | 136.00 feet by land now or formerly of Philip Veillette, et al; |
| NORTHEASTERLY: | again 99.25 feet by land now or formerly of Philip Veillette, et |
| SOUTHEASTERLY: | al; again 43 feet, more or less, by Baldwin Street, fka Mill |
| SOUTHEASTERLY: | Street; again |
| SOUTHWESTERLY: | by Baldwin Street, fka Mill Street; |
| NORTHWESTERLY: | 251.25 feet by land now or formerly of the Church of the Immaculate Conception; |
| | 136.68 feet by land now or formerly of the Church of the Immaculate Conception. |

A portion of the parcel is shown on a certain Map entitled, "Map of Land of Scovill Manufacturing Company, Waterbury, Conn., The A.J. Patton Co. Surveyor, Waterbury, Conn. Oct. 1975, Scale 1" = 50' Revised April 9, 1976, Sheet 1 of 8"" on file in the Waterbury Town Clerk's Office in Map Drawer VI,

Page 35.

*Office of the President*
*Chad W. Wable, FACHE*

Saint Mary's
HEALTH SYSTEM

September 18, 2015

JANEANNE LUBIN-SZAFRANSKI
SAINT FRANCIS CARE, INC.
114 WOODLAND ST
HARTFORD, CT 06105

TRINITY HEALTH CORPORATION
20555 VICTOR PARKWAY
LIVONIA, MI 48152

**RE: Supplemental Disclosure Letter**

Dear Ms. Lubin-Szafranski:

In connection with the Transfer Agreement, dated September 18, 2015, by and among Saint Francis Care, Inc. ("Saint Francis"), Trinity Health Corporation ("Trinity"), Saint Mary's Health System, Inc., and Saint Mary's Hospital, Inc. ("Saint Mary's") (collectively, the "Parties"), Saint Mary's has requested to make several supplemental disclosures herein and Trinity Health and Saint Francis have agreed thereto. By signing below, the Parties agree the below disclosures are valid disclosures to the Transfer Agreement and have the same force and effect as the Transfer Agreement Disclosure Schedules. Based on the foregoing, Saint Mary's makes the following supplemental disclosures:

6.15

[redacted]

6.19:

Initial Breach Report, dated February 28, 2014, individual patient - unauthorized access/disclosure

Initial Breach Report, dated February 28, 2014, five patients affected - mail incorrectly addressed

6.22(b)

The current determination letter for the 401(k) Plan, dated January 18, 2012, is conditioned upon the timely execution of certain amendments. Exact evidence of the timely execution of these amendments has not been provided.

6.22(f):

Policies and procedures to comply with the HIPAA privacy and security regulations have not been specifically adopted for group health plans.

6.22(k):

Saint Mary's Hospital has a number of individual non-competition, non-disclosure and severance payment agreements in effect with a number of Officers and Executives of Saint Mary's Hospital. The Agreements, and certain amendments, are generally dated from 2008 to 2014. The severance payment obligations vary by agreement and often are measured based on years of service at the time of termination with maximum dollar amount limits. However, because the individual payments by Saint Mary's Hospital are incurred for employment terminations which occur with or without cause, and because the agreements contain required terminated employee release of claims provisions for the payments to occur, it appears likely that Section 409A compliance issues will therefore exist. Such Agreements may be viewed by the IRS as deferred compensation agreements in substance, and because of the required releases of claims, as well as the total amounts to be paid by Saint Mary's Hospital, IRS Notices 2010-6 and 2010-80 may provide relief for any desired amendments to be implemented for purposes of complying with Section 409A, and so as to legally avoid potential IRS penalties, individual income tax liabilities, interest and non-payment penalties.

Very truly yours,

Dated: 9-18-15, 2015

**SAINT MARY'S HEALTH SYSTEM, INC.**

By: _____
Name: Chad W. Waible, FACHE
Title: Chief Executive Officer

Dated: 9-18-15, 2015

**TRINITY HEALTH CORPORATION**

By: _____
Name:
Title:

Dated: 9-18-15, 2015

**SAINT FRANCIS CARE, INC.**

By: _____
Name:
Title:

Dated: 9-18-15, 2015

**TRINITY HEALTH CORPORATION**

By: _____
Name:
Title:

Dated: 9-18-15, 2015

**SAINT FRANCIS CARE, INC.**

By: _____
Name:
Title:

## CLOSING DISCLOSURE SCHEDULE

This Closing Disclosure Schedule is being delivered in anticipation of Closing pursuant to Section 5.01 the terms of that certain Transfer Agreement (the **"Agreement"**), dated as of September 18, 2015, by and among Trinity Health Corporation, an Indiana nonprofit corporation (**"Trinity Health"**), Trinity Health – New England, Inc. (f/k/a Saint Francis Care, Inc.), a Connecticut nonstock corporation (**"NE-RHM"**), and Saint Mary's Health System, Inc. (**"SMHS"**) and Saint Mary's Hospital, Inc. (**"SMH"**), both Connecticut nonstock corporations (collectively, **"Saint Mary's"**).

Capitalized terms used in this Disclosure Schedule and not otherwise defined herein shall have the respective meaning ascribed thereto in the Agreement. Any headings herein are included for convenience of reference only and shall be ignored in the construction and interpretation hereof. Any summary of or reference to a written document in this Disclosure Schedule shall be deemed to refer to the version of such document in the form that it has been made available to NE-RHM and Trinity Health via the electronic data room set up for this transaction at https://datasite.merrillcorp.com.

## DISCLOSURE SCHEDULES


Schedule 1A _____ Knowledge of Saint Mary's
Schedule 1B _____ Knowledge of NE-RHM
Schedule 1C _____ Knowledge of Trinity Health
Schedule 2.01 _____ SMH Board Members
Schedule 3.02 _____ NE-RHM Board of Directors - Saint Mary's Members
Schedule 6.04 _____ Conflicts/Consents
Schedule 6.05 _____ Organizational Chart
Schedule 6.07 _____ Undisclosed Liabilities
Schedule 6.08 _____ Absence of Certain Changes, Events, Conditions
Schedule 6.09 _____ Material Contracts
Schedule 6.09(c) _____ Material Contracts - Validity
Schedule 6.10 _____ Permitted Encumbrances
Schedule 6.11 _____ Condition and Sufficiency of the Saint Mary's Assets
Schedule 6.12(a) _____ Owned Real Property
Schedule 6.12(b) _____ Leased Real Property
Schedule 6.14(a) _____ Legal Proceedings
Schedule 6.14(b) _____ Governmental Orders
Schedule 6.15(a) _____ Compliance With Laws
Schedule 6.16(a) _____ Medicare - Plans of Correction
Schedule 6.16(b) _____ Medicare - Claims
Schedule 6.16(d) _____ Medicare - Accreditation Surveys/Deficiency List
Schedule 6.19 _____ HIPAA - Breach Notifications
Schedule 6.20 _____ Affiliate Transactions
Schedule 6.21(e) _____ Environmental
Schedule 6.22(a) _____ Employee Benefit Plans
Schedule 6.22(b) _____ Benefit Plans - Compliance
Schedule 6.22(c) _____ Employee Pension Benefit Plan Liability
Schedule 6.22(d) _____ Multiemployer Plan Liability
Schedule 6.22(e) _____ Church Plans
Schedule 6.22(f) _____ Employee Welfare Benefit Plans
Schedule 6.22(g) _____ Effect of Execution and Consummation of Agreement on Saint Mary's Benefit Plans

Schedule 6.23 _____ Employment Matters

Schedule 6.24 _____ Taxes

Schedule 6.25 _____ Insurance

Schedule 7.04 _____ Conflicts - Trinity Health and NE-RHM

Schedule 7.08(a) _____ Compliance with Laws - NE-RHM

Schedule 7.09(a) _____ Medicare - Plans of Correction - NE-RHM

Schedule 7.09(b) _____ Medicare/Medicaid - NE-RHM Claims

Schedule 7.12 _____ HIPAA - Breach Notifications - NE-RHM

Schedule 8.08(a) _____ Insured Real Property

**Schedule 1A**

**Knowledge of Saint Mary's**

No updates.

**Schedule 1B**

**Knowledge of NE-RHM**

1. Christopher M. Dadlez, President and CEO
2. David Bittner, Senior Vice President and CFO
3. Janeanne C. Lubin-Szafranski, Senior Vice President and General Counsel
4. Jennifer S. Schneider, Vice President of Finance

**Schedule 1C**

**Knowledge of Trinity Health**

No updates.

**Schedule 2.01**

**SMH Board Members**

**Directors and Officers**

- Mengacci, Esq., Joseph
- Pugh, Richard
- Wable, Chad
- Mattie, Angela
- Roscoe, Robert

**Directors**

- Albert, Eric
- Albini, M.D., S. Mark
- Bachhuber, Theresa M.
- Ford, Father Christopher
- Gumbardo, M.D., Robert
- Richi, M.D., Aziz
- Rodriguez, Felix
- Roer, M.D., David
- Sullivan, Esq., Christine
- Summa, Esq., Kara

**Schedule 3.02**

**Board of Directors of NE-RHM - Saint Mary's Members**

Notwithstanding the provisions of the Transfer Agreement, the Parties hereto agree that the following individuals will be added to the Board of Directors of NE-RHM effective as of September 1, 2016:

Garret Casey, Jr.

Stephen R. Griffin, Esq.

**Schedule 6.04**

**Conflicts/Consents**

(a) No updates.

(b) No updates.

(c)(i) No updates.

(1) Waterbury Hospital, as member of the Harold Leever Regional Cancer Center, Inc., provided consent in September 2015. Waterbury Hospital and SMH recently filed a CON modification in anticipation of the transaction contemplated in the Transfer Agreement.

(2) NVRA consent provided to NE-RHM and Trinity Health

(3) Notice to DSS required within 35 days post-closing

(4) Craneware consent letter sent out. Awaiting receipt

(5) Notice letter to McKesson provided to NE-RHM, Trinity Health

(6)

a. Consent of Archdiocese provided to NE-RHM, Trinity Health.
b. Consent of Holy See, Roman Catholic Church provided to NE-RHM, Trinity Health
c. OHCA approval received and provided to all parties
d. Notice provided to Connecticut Attorney General
e. FTC did not provide comment

(7) Upon further review, consent of Diagnostic Imaging of Southbury, LLC is not required.

(8) Per Section 10.01 of the Indenture of Lease by and between Park West, LLC and Saint Mary's Hospital, Park West, LLC required consent to transfer the Indenture of Lease. Proof of Park West, LLC's consent to the transfer has been provided to NE-RHM and Trinity Health.

(9) Per Section 21(a) of the Lease by and between RPH Highland LLC and Saint Mary's Hospital, RPG Highland LLC required consent to assign the Lease. Proof of RPH Highland LLC's consent to the assignment has been provided to NE-RHM and Trinity Health.

(c)(ii) No updates.

(c)(iii) No updates.

(c)(iv) No updates.

(c)(v) Pursuant to Section 18.d. of the Master Service Agreement, dated January 5, 2009, by and between SMH and Connecticut Children's Medical Center ("CCMC"), CCMC may terminate the Master Service Agreement by providing written notice to SMH upon a Change of Control. Change of Control includes a change in the membership of SMH. SMH and CCMC remain on good terms and CCMC is not terminating the agreement.

(d) No updates.

**Schedule 6.05**

**Organizational Chart**

No updates.

**Schedule 6.07**

**Undisclosed Liabilities**

Webster Loan to be paid on August 1, 2016 and all necessary releases filed thereafter.

**Schedule 6.08**

Absence of Certain Changes, Events, Conditions

Schedule 6.08 is limited to changes, events, conditions from Balance Sheet Date (6/30/2015) until Signature Date (9/18/15) and thus no update is required

**Schedule 6.09**

**Material Contracts**

(i) Each Contract involving aggregate consideration in excess of $100,000

See attached.

(ii) All Contracts that relate to the acquisition of any business, a material amount of equity or assets of any other Person or any real property (whether by merger, sale of stock or equity, sale of assets or otherwise), in each case involving amounts in excess of $100,000

1. Purchase and Sale Agreement by and between Peter Greco, M.D., Thomas Greco, M.D., and Saint Mary's Health System, Inc., for the Units 3-G and 3-F in the Medical Office Building located at 133 Scovill Street in Waterbury, CT.

(iii) All Contracts with any Governmental Authority

No updates.

(iv) Any Contracts to which Saint Mary's or a Saint Mary's Controlled Subsidiary is a party that provide for any joint venture, partnership or similar arrangement

No updates.

(v) All Contracts between or among Saint Mary's on the one hand and any Affiliate of Saint Mary's on the other hand

No updates.

(vi) All collective bargaining agreements or Contracts with any union, works council, or labor organization to which SMH or a SMH Controlled Subsidiary is a party

No updates.

(vii) All Contracts relating to indebtedness having an outstanding principal amount of $100,000

No updates.

SAINT MARY'S HOSPITAL ATTACHMENT TO CLOSING SCHEDULE 6.09(a)(i)

| CONTRACT NUMBER | VENDOR OTHER PARTY |
|---|---|
| 1001.1319C | Yale University School of Medicine |
| 1001.1323C | Press Ganey |
| 1001.1326E | PAC Planning Services, LLC |
| 1002.1328C | Michael Malinics, MD |
| 1002.1330C | Mary L. Aquavia, MD |
| 1001.1341E | NVLM, Inc |
| 1001.1351C | Berkeley Research Group (BRG) |
| 1002.1354C | Pruner, Joseph MD |
| 1001.1355C | Surgical Monitoring Services, Inc. d/b/a Sentient |
| 1002.1358C | Ghisa, MD Adriana |
| 1002.1368C | Nicolescu, Mirela MD |
| 1002.1372C | 1389 West Main Street, Suite 224, Waterbury CT |
| 1002.1370C | Gniadek, Thomas MD |
| 1002.1371C | Gniadek, Thomas MD Asset Purchase Agreement |
| 1001.1381C | H2C (Hammond) |
| 1002.1382C | Kett, Kevin MD |
| 1002.1383C | Chang, MD Yueming |
| 1001.1385C | RelayHealth |
| 1002.1389C | United Health Care |
| 1001.1401C | Atrion Networking Corporation |
| 1001.1409C | Medtronic, Inc. |
| 1002.1410C | Singanamala, MD Santhi |
| 1002.1417C | Patel, MD Kush |

| | |
|---|---|
| 1002.1416C | Rosado, MD Ana |
| 1002.1418C | Cheema, Rabia |
| 1002.1420C | 1389 West Main Street, Suite 224, Waterbury CT 06708 |
| 1002.1421C | Shetty, Shopa MD |
| 1002.1423C | Gnanaraj, Joseph MD |

UPDATE TO SCHEDULE 6.09(a)(i) AS REFLECTED IN INITIAL DISCLOSURE SCHEDULES

## MASTER COMMERCIAL CONTRACTS

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.1002C | Saint Mary's Hospital | Geonetric Technology |
| 1001.1007E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1008E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1009E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1012C | Saint Mary's Hospital | McKesson Corporation |
| 1001.1016C | Saint Mary's Hospital | Medtronic, Inc. |
| 1001.1017C | Saint Mary's Hospital | Medtronic, Inc. |
| 1001.1019C | Saint Mary's Hospital | Quinnipiac University |
| 1001.1024E | Saint Mary's Hospital | Nuance Powerscribe |
| 1001.1025E | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.1050C | Saint Mary's Hospital | RelayHealth |
| 1001.1053C | Saint Mary's Hospital | RelayHealth |
| 1001.1054C | Saint Mary's Hospital | Connecticut Hospital Association |
| 1001.1060C | Saint Mary's Hospital | Roche Diagnostics Corporation |
| 1001.1063E | Saint Mary's Hospital | Nuance Communications, Inc. |
| 1001.1064E | Saint Mary's Hospital | McKesson Corporation |
| 1001.1065C | Saint Mary's Hospital | McKesson Technologies, Inc. |
| 1001.1071C | Saint Mary's Hospital | Leidos Health LLC |
| 1001.1085C | Saint Mary's Hospital | JVK Operations |
| 1001.1092C | Saint Mary's Hospital | WB Mason |
| 1001.1099C | Saint Mary's Physician Partners, LLC | Naugatuck Valley Women's Health Specialists, PC |
| 1001.1100E | Saint Mary's Hospital | Wellsoft Corporation |
| 1001.1120C | Saint Mary's Hospital | Medtronic USA, Inc. |
| 1001.1121C | Saint Mary's Hospital | Allscripts Healthcare, LLC |
| 1001.1160C | Saint Mary's Hospital | Cardinal Health 200, LLC |
| 1001.1165C | Saint Mary's Hospital | Kronos |
| 1001.1168C | Saint Mary's Hospital | Siemens Healthcare Diagnostics Inc. |
| 1001.1171C | Saint Mary's Hospital | Grainger Industrial Supply |
| 1001.1173C | Saint Mary's Hospital | Anthelio Healthcare Solutions, Inc. |
| 1001.1177C | Saint Mary's Hospital | Truven Health |
| 1001.1178C | Saint Mary's Hospital | Spendadvisor |
| 1001.1185C | Saint Mary's Hospital | Universal Background Screening |
| 1001.1189C | Saint Mary's Hospital | Intuitive Surgical, Inc. |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.1191C | Saint Mary's Hospital | Beckman Coulter |
| 1001.1193C | Saint Mary's Hospital | Draeger Medical, Inc. |
| 1001.1204C | Saint Mary's Hospital | Cross Country Staffing |
| 1001.1221C | Saint Mary's Hospital | Bard Peripheral Vascular, Inc. |
| 1001.1225C | Saint Mary's Hospital | NVMRI |
| 1001.1226C | Saint Mary's Hospital | Edwards Lifesciences LLC |
| 1001.1237C | Saint Mary's Hospital | Covidien Sales, LLC |
| 1001.1248C | Saint Mary's Hospital | McKesson Technologies, Inc. |
| 1001.1250C | Saint Mary's Hospital | St. Jude Medical |
| 1001.1274C | Saint Mary's Hospital | PMA Management Corp. of New England |
| 1001.1275C | Saint Mary's Hospital | Neuro Enterprises, LLC |
| 1001.1286C | Saint Mary's Hospital | Baxter Healthcare Corporation |
| 1001.190C | Saint Mary's Hospital | St Jude Medical US Division |
| 1001.210C | Saint Mary's Hospital | Craneware, Inc. |
| 1001.216C | Saint Mary's Hospital | University of Connecticut School of Medicine |
| 1001.219C | Saint Mary's Hospital | Cardinal Health 200, LLC |
| 1001.228C | Saint Mary's Hospital | Naugatuck Valley Lawn Maintenance, Inc. |
| 1001.235E | Saint Mary's Hospital | School Readiness Grant Program |
| 1001.266E | Saint Mary's Hospital | Connecticut Children's Medical Center |
| 1001.287C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.304E | Saint Mary's Hospital | Stryker |
| 1001.332C | Saint Mary's Hospital | Heart Center of Greater Waterbury, Inc. |
| 1001.354E | Saint Mary's Hospital | Sodexho Operations, LLC |
| 1001.367E | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.393C | Saint Mary's Hospital | 3M Health Care Service Center |
| 1001.411C | Saint Mary's Hospital | Cardinal Health 200, LLC |
| 1001.420C | Saint Mary's Hospital | Western Connecticut State University |
| 1001.427C | Saint Mary's Hospital | Sodexho Operations, LLC |
| 1001.430C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.433C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.44C | Saint Mary's Hospital | Toshiba America Medical Systems Inc. |
| 1001.44C | Saint Mary's Hospital | Toshiba America Medical Systems Inc. |
| 1001.468C | Saint Mary's Hospital | University of Connecticut, Department of Allied Health Sciences |
| 1001.469C | Saint Mary's Hospital | University of Connecticut School of Nursing |
| 1001.474C | Saint Mary's Hospital | Haemonetics Corporation |
| 1001.47C | Saint Mary's Hospital | Siemens Medical Solutions USA, Inc. |
| 1001.482C | Saint Mary's Hospital | Department of Public Health |
| 1001.489C | Saint Mary's Hospital | Gateway Community College |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.490C | Saint Mary's Hospital & Health System | Santa Buckley Energy, Inc. |
| 1001.495E | Saint Mary's Hospital | GE Healthcare |
| 1001.519C | Saint Mary's Hospital | University of Connecticut School of Social Work |
| 1001.521C | Saint Mary's Hospital | Department of Social Services |
| 1001.525C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.541C | Saint Mary's Hospital | Waterbury Department of Education |
| 1001.54C | Saint Mary's Hospital | 3M Health Care Service Center |
| 1001.590C | Saint Mary's Hospital | bioMerieux, Inc. |
| 1001.592C | Saint Mary's Hospital | American National Red Cross |
| 1001.603C | Saint Mary's Hospital | Unitex Textile Rental Services |
| 1001.608C | Saint Mary's Hospital | City-Wide Delivery Service, Inc. |
| 1001.632C | Saint Mary's Hospital | McKesson Health Solutions, LLC |
| 1001.633E | Saint Mary's Hospital | Otis Elevator Company |
| 1001.653C | Saint Mary's Hospital | Siemens Industry, Inc. |
| 1001.668C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.676E | Saint Mary's Hospital | SkillSurvey |
| 1001.679C | Saint Mary's Hospital | 3M Health Care Service Center |
| 1001.681C | Heart Center of Greater Waterbury | University of Connecticut Health Center Department of Finance |
| 1001.682C | Saint Mary's Hospital | Med3000, Inc. |
| 1001.688C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.691C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.694C | Saint Mary's Hospital | Healthstream, Inc. |
| 1001.749C | Saint Mary's Hospital | Connecticut Light and Power Company |
| 1001.750C | Saint Mary's Hospital | Connecticut Light and Power Company |
| 1001.768C | Saint Mary's Health System | Axiom Group, LLC |
| 1001.783C | Saint Mary's Hospital | Best Practices, Inc. |
| 1001.786C | Saint Mary's Hospital | Precyse Solutions, LLC |
| 1001.787E | Saint Mary's Hospital | GE Medical Systems |
| 1001.788C | Saint Mary's Hospital | Financial Health Strategies, Inc. |
| 1001.811C | Saint Mary's Hospital | Department of Public Health |
| 1001.814C | Saint Mary's Hospital | Executive Health Resources, Inc. (E.H.R.) |
| 1001.820E | Saint Mary's Hospital | Dell |
| 1001.8221C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.825E | Saint Mary's Hospital | Diagnostic Equipment Service Corporation (DESCO) |
| 1001.829C | Saint Mary's Hospital | Precyse Solutions, LLC |
| 1001.840C | Saint Mary's Hospital | University of Connecticut School of Allied Health |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.852C | Saint Mary's Hospital | Bay State Anesthesia |
| 1001.853C | Saint Mary's Hospital | Department of Public Health |
| 1001.858C | Saint Mary's Hospital | Anthelio Healthcare Solutions, Inc. |
| 1001.860C | Saint Mary's Hospital | Syntrac Cardinal Health |
| 1001.861C | Saint Mary's Hospital | Sunquest Information Systems, Inc. |
| 1001.866C | Saint Mary's Health System | VPNE Parking Solutions, LLC |
| 1001.882C | Saint Mary's Hospital | Naugatuck Valley Community College |
| 1001.884C | Saint Mary's Hospital | Olympus America, Inc. |
| 1001.886C | Saint Mary's Hospital | Telephone Nurse Triage - Kanagaratnam Jegathesan, MD |
| 1001.890E | Saint Mary's Hospital | Corepoint |
| 1001.891C | Saint Mary's Hospital | Advantage RN |
| 1001.944C | Saint Mary's Hospital | RelayHealth |
| 1001.950C | Saint Mary's Hospital | Xtend Healthcare, LLC |
| 1001.962C | Saint Mary's Hospital | Precyse Solutions, LLC |
| 1001.979C | Saint Mary's Hospital | Yale University School of Medicine |
| 1001.997C | Saint Mary's Health System, Inc. | McKesson Corporation |
| 1002.1048C | Franklin Medical Group, P.C. | Nuance Communications, Inc. |
| 1002.1090C | Franklin Medical Group, P.C. | Digestive Disease Center of CT, LLC |
| 1002.244C | Franklin Medical Group, P.C. | Naugatuck Valley OB-GYN Associates, PC |
| 1002.448C | Franklin Medical Group, P.C. | Department of Public Health |
| 1002.530C | Franklin Medical Group, P.C. | Napiello, Virginia APRN |
| 1002.888E | Franklin Medical Group, P.C. | Phoenix Internal Medicine Associates, LLC |
| 1002.958C | Franklin Medical Group, P.C. | VENDOR INCORRECTLY LABELED ON LIST AS: University of Connecticut Health Center Department of Finance. CORRECT VENDOR is Night Nurse, Inc. |
| 1002.959C | Franklin Medical Group, P.C. | Thames Records Management |
| 1002.967C | Franklin Medical Group, P.C. | City-Wide Delivery Service, Inc. |
| 1002.974C | Franklin Medical Group, P.C. | Intuitive Surgical, Inc. |
| 1010.966C | Saint Mary's Hospital | Healogics Wound Care & Hyperbaric Services, Inc. |
| 1010.968C | Saint Mary's Hospital | Commerce Bank |
| 1010.978C | Saint Mary's Hospital | Central Connecticut State University |
| 1010.985C | Saint Mary's Hospital | Jackson & Coker Permanent, LLC |

## NON-PROVIDER LEASES

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 2005.445C | Saint Mary's Hospital, Inc. | Union Square Southbury, LLC (Landlord) |
| 2005.445C | Saint Mary's Hospital, Inc. | Associated Physicians of Southbury, P.C. (Subtenant) |
| 2005.762C | Saint Mary's Hospital, Inc. | 146 Highland Associates, LLC (Landlord) |
| 2005.934E | Saint Mary's Hospital, Inc. | 1981 East Main Street, LLC (Landlord) |
| 2005.934E | Saint Mary's Hospital, Inc. (Sublandlord) | Inwelligent Healthcare, Inc. (Subtenant) |
| 2007.104C | Saint Mary's Hospital, Inc. | Scovill Commons Partners, LLC (Landlord) |
| 2007.1186E | Saint Mary's Hospital, Inc. | Subway Real Estate Corp. (Tenant) |
| 2007.1227C | Saint Mary's Hospital, Inc. | Northwest CT Public Safety Communications Center Inc. (Tenant) |
| 2007.245C | Saint Mary's Hospital Corporation | Spectrum Square, LLC (Landlord) |
| 2007.273E | Saint Mary's Hospital, Inc. | Fraydun Enterprises, LLC (Landlord) |
| 2007.285E | Saint Mary's Hospital, Inc. | Fraydun Enterprises, LLC (Landlord) |
| 2007.509E | Saint Mary's Hospital Corporation | Scovill Commons Partners, LLC (Landlord) |
| 2007.760C | Saint Mary's Hospital | JPMCC 2003-ML1 Naugatuck Retail, LLC (Landlord) |
| 2007.761C | Saint Mary's Hospital | Park West, LLC (Landlord) |
| 2007.765E APPRAISAL/OPINION - NOT REVIEWED | N/A | N/A |
| 2013.1129C | Franklin Medical Group, P.C. | 1177, LLC (Landlord) |

## PROVIDER CONTRACTS

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.1072C | Saint Mary's Hospital | Singanamala, Santhi MD |
| 1001.1082C | Saint Mary's Hospital | Waterbury Pulmonary Associates, LLC |
| 1001.1105C | Saint Mary's Hospital | Brittny Williams Howell, MD |
| 1001.110C | Saint Mary's Hospital | Martinucci, Erica MD |
| 1001.1176C | Saint Mary's Physician Partners, LLC | |
| 1001.1216C | Saint Mary's Hospital | Connecticut Children's Specialty Group, Inc. |
| 1001.1298C | Saint Mary's Hospital | Connecticut Children's Specialty Group, Inc. |
| 1001.323E | Saint Mary's Hospital | Connecticut Children's Medical Center |
| 1001.342C | Saint Mary's Hospital | Consultants In Pathology, PC |
| 1001.37C | Saint Mary's Hospital | Rho, Mira MD |
| 1001.39C | Saint Mary's Hospital | Roer, David MD |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1001.407C | Saint Mary's Hospital | Neurosurgery Orthopaedics & Spine Specialists PC |
| 1001.783E | Saint Mary's Hospital | EmCare, Inc. AND EmCare, Inc. |
| 1001.480C | Saint Mary's Hospital | Milford Anesthesia Associates, LLC |
| 1001.543E | Saint Mary's Hospital | Koteles, Alicia MD |
| 1001.547C | Saint Mary's Hospital | Raissi, Sina MD |
| 1001.570C | Saint Mary's Hospital (Naugatuck Valley Surgical Center Limited Partnership) | SurgiCenter Anesthesiologists, PC |
| 1001.580C | Saint Mary's Hospital | Mayo Medical Laboratories |
| 1001.593C | Saint Mary's Hospital | Zarif, Abdul MD |
| 1001.68C | Saint Mary's Hospital | Zarif, Abdulmasih MD |
| 1001.764C | Saint Mary's Hospital | Naugatuck Valley Women's Health Specialists, PC |
| 1001.988E | Saint Mary's Hospital | Wellmore Behavioral Health |
| 1002.1020C | Franklin Medical Group, P.C. | Monzurul Chowdhury, MD |
| 1002.1031C | Franklin Medical Group, P.C. | Bechoi Saleib, MD |
| 1002.1037C | Franklin Medical Group, P.C. | Anna Freitag, MD |
| 1002.1051C | Franklin Medical Group, P.C. | Frank Longo, MD |
| 1002.1067C | Franklin Medical Group, P.C. | Ken Matsuo |
| 1002.1069C | Franklin Medical Group, P.C. | Joseph Bowen, MD |
| 1002.1101C | Franklin Medical Group, P.C. | Marano, Albert |
| 1002.1102C | Franklin Medical Group, P.C. | Lyall, Bhupinder |
| 1002.1103C | Franklin Medical Group, P.C. | Feinberg, Michael |
| 1002.1104C | Franklin Medical Group, P.C. | Kraus, Mark, MD |
| 1002.1107C | Franklin Medical Group, P.C. | Anupama Paranandi, MD Infectious Disease |
| 1002.1109C | Franklin Medical Group, P.C. | Sallie Carrington, DO |
| 1002.1110C | Franklin Medical Group, P.C. | Preissler, MD Paul |
| 1002.1112C | Franklin Medical Group, P.C. | Garsten, MD Joel |
| 1002.1113C | Franklin Medical Group, P.C. | Burlison, MD Kathleen |
| 1002.1117C | Franklin Medical Group, P.C. | Cohen, Matthew, MD |
| 1002.113C | Franklin Medical Group, P.C. | Palesty, J Alexander MD |
| 1002.116C | Franklin Medical Group, P.C. | Wetmore, Robert S MD, PC |
| 1002.117C | Franklin Medical Group, P.C. | Sieling, Beth Ann MD |
| 1002.118C | Franklin Medical Group, P.C. | Sookhan, Nicole MD |
| 1002.11C | Franklin Medical Group, P.C. | Rosenhein, Brian DO |
| 1002.1208C | Franklin Medical Group, P.C. | Giacomazzi, Peter, MD |
| 1002.120C | Franklin Medical Group, P.C. | Galal, Magdy MD |
| 1002.1238C | Franklin Medical Group, P.C. | Shetty, MD Shohan |
| 1002.1242C | Franklin Medical Group, P.C. | Neamtu, MD Andreea |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1002.1268C | Franklin Medical Group, P.C. | Gork MD, Ahmet |
| 1002.1269C | Franklin Medical Group, P.C. | Khan MD, Tasneem |
| 1002.1270C | Franklin Medical Group, P.C. | Salerno MD, John |
| 1002.1271C | Franklin Medical Group, P.C. | Polokoff MD, Ellen |
| 1002.1272C | Franklin Medical Group, P.C. | Leal MD, Daniel |
| 1002.1277C | Franklin Medical Group, P.C. | Medrano MD, Consuelito |
| 1002.1278C | Franklin Medical Group, P.C. | Esemuede MD, Iyare |
| 1002.1281C | Franklin Medical Group, P.C. | Thiruvengadam MD, Sudha |
| 1002.12C | Franklin Medical Group, P.C. | Sheikh, Abdul Majeed MD |
| 1002.1300C | Franklin Medical Group, P.C. | Carolyn O'Connor, MD |
| 1002.1303C | Franklin Medical Group, P.C. | Greco, Thomas MD |
| 1002.1304C | Franklin Medical Group, P.C. | Ann Marie Conti-Kelly, MD |
| 1002.15C | Franklin Medical Group, P.C. | Te, Victorio Go MD |
| 1002.18E | Franklin Medical Group, P.C. | Simms, Michael F MD |
| 1002.20C | Franklin Medical Group, P.C. | Imam, Azhar MD |
| 1002.22C | Franklin Medical Group, P.C. | Nawaz, Shah MD |
| 1002.23C | Franklin Medical Group, P.C. | Alston, Shawnette MD |
| 1002.25C | Franklin Medical Group, P.C. | Beri, Rohit MD |
| 1002.26C | Franklin Medical Group, P.C. | Bogursky, Sondra MD |
| 1002.299C | Franklin Medical Group, P.C. | Anthony, J Robert MD |
| 1002.29C | Franklin Medical Group, P.C. | Colodner, Gregory MD |
| 1002.34C | Franklin Medical Group, P.C. | Newell, Rebecca O MD |
| 1002.36C | Franklin Medical Group, P.C. | Ouellette, Jason MD |
| 1002.379C | Franklin Medical Group, P.C. | Chere, Mitch MD |
| 1002.3C | Franklin Medical Group, P.C. | Ramos, Rey MD |
| 1002.41C | Franklin Medical Group, P.C. | Talwalkar, Jaideep MD |
| 1002.42C | Franklin Medical Group, P.C. | Vaezy, Ali MD |
| 1002.432C | Franklin Medical Group, P.C. | Ndiaye, Mouhamed A MD |
| 1002.457C | Franklin Medical Group, P.C. | Gega, Arjet MD |
| 1002.493C | Franklin Medical Group, P.C. | Kelly, Paul MD |
| 1002.501C | Franklin Medical Group, P.C. | Zhang, He MD |
| 1002.503C | Franklin Medical Group, P.C. | Baba, Carolina Borz MD |
| 1002.508C | Franklin Medical Group, P.C. | Rubenstein, Stephen MD |
| 1002.513C | Franklin Medical Group, P.C. | Rovetto, Allyson MD |
| 1002.515C | Franklin Medical Group, P.C. | Brenes, Laura C MD |
| 1002.516C | Franklin Medical Group, P.C. | Zlotoff, Ronald A MD |
| 1002.528C | Franklin Medical Group, P.C. | D'Souza, Bernard MD |
| 1002.55C | Franklin Medical Group, P.C. | Almeida, Carlos MD |

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 1002.569C | Franklin Medical Group, P.C. | Richi, Maysoun MD |
| 1002.56C | Franklin Medical Group, P.C. | Alvarez, Alexander J MD |
| 1002.58C | Franklin Medical Group, P.C. | Testa, John MD |
| 1002.59C | Franklin Medical Group, P.C. | Uberti, James G MD |
| 1002.614C | Franklin Medical Group, P.C. | Richi, Aziz MD |
| 1002.655C | Franklin Medical Group, P.C. | Quinn, Edmund |
| 1002.685C | Franklin Medical Group, P.C. | Karen Kennedy |
| 1002.69C | Franklin Medical Group, P.C. | Cardiology Associates of Waterbury, PC |
| 1002.756C | Franklin Medical Group, P.C. | Zefirova, Julia MD |
| 1002.758C | Franklin Medical Group, P.C. | Cumberland, Melisha MD |
| 1002.817C | Franklin Medical Group, P.C. | Mario Perez |
| 1002.827E | Franklin Medical Group, P.C. | Seli, Meltem MD |
| 1002.848C | Franklin Medical Group, P.C. | Albajrami, Oltjon MD |
| 1002.879C | Franklin Medical Group, P.C. | Ranjan, Saurabh MD |
| 1002.887C | Franklin Medical Group, P.C. | El-Hennawy, Magdy Sayed MD |
| 1002.915C | Franklin Medical Group, P.C. | Philip R. Corvo, MD |
| 1002.93C | Franklin Medical Group, P.C. | Naugatuck Valley OBGYN PC |
| 1002.943C | Franklin Medical Group, P.C. | Maria Dawe, MD |
| 1002.961C | Franklin Medical Group, P.C. | Macaron, Shady Hafez MD |
| 1002.972C | Franklin Medical Group, P.C. | Naugatuck Valley Women's Health Specialists, PC |
| 1002.993C | Franklin Medical Group, P.C. | Aditi Mukherji, MD |
| 1002.995C | Franklin Medical Group, P.C. | Rebecca Scandrett, MD |
| 1002.244C | Franklin Medical Group, P.C. | Naugatuck Valley OB-GYN Associates, PC |
| 1001.266E | Saint Mary's Hospital | Connecticut Children's Medical Center |

## PROVIDER LEASES

| CONTRACT NO. | SAINT MARY'S ENTITY | VENDOR / PROVIDER / NON-PROVIDER |
|---|---|---|
| 2005.364C | Saint Mary's Hospital | Saint Mary's Hospital |
| 2007.1285C | Saint Mary's Hospital | LJL Properties, LLC |
| 2007.296C | Saint Mary's Hospital | West Main Medical, LLC, a Connecticut limited liability company, as Landlord |
| 2008.534C | Primary Care Partners, P.C. | Greater Waterbury Primary Care Associates, P.C., as Tenant |

**Schedule 6.09(c)**

**Material Contracts - Validity**

To the knowledge of Saint Mary's, each Material Contract is valid and binding on Saint Mary's or a Saint Mary's Controlled Subsidiary, as applicable, in accordance with its terms and is in full force and effect;

To the Knowledge of Saint Mary's, no party is in breach of or default under (or is alleged to be in breach of or default under), or has provided or received any notice of any intention to terminate, any Material Contract; and

No event or circumstance has occurred that, with notice or lapse of time or both, would constitute an event of default under any Material Contract or result in a termination thereof or would cause or permit the acceleration or other changes of any right or obligation or the loss of any benefit thereunder.

**Schedule 6.10**

**Permitted Encumbrances**

(1) Filing No. 0003104990 in favor of Wells Fargo Equipment Finance, Inc.

(2) Filing No. 0003013154 in favor of General Electric

**Schedule 6.11**

**Condition and Sufficiency of the Saint Mary's Assets**

No updates.

**Schedule 6.12(a)**

**Owned Real Property**

The following units have been added since the Signing Date:

- Office Condominium Unit 2I (206), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3G (304), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3F (306), 133 Scovill Street, Waterbury CT

The following parcel was sold subsequent to the Signing Date:

All that certain piece or parcel of land situated on the southerly side of French Street in the Town of Watertown, County of Litchfield, State of Connecticut shown as Lot 34A Area = 25,515 S.F. on 0.59 acres on a map entitled, "Division of land 'First Cut' owned by SAINT MARY'S HEALTH SYSTEM, INC. 290 French Street Watertown Connecticut Scale 1" = 30' dated 3-21-14 Meyers Associates P.C. 60 Linden Street Waterbury, Connecticut 06702". Said premises being bounded and described as follows:

Beginning at a point on the southerly street line of French Street, said point being just northerly of the northwest corner of land now or formerly of Mark & Cheryl C. Woodruff, and also being the northeast corner of the herein described parcel of land; thence running S 09°29'38" E 273.42' along the westerly street line of French Street and along land of said Woodruff, in part by each, to a point; thence turning and running S 76°58'40" W 99.57' along land now or formerly of Town of Watertown, to a point; thence turning and running N 04°13'33" W 325.46' along Lot 34B, to a point on the said southerly street line of French Street; thence turning and running S 66°50'20" E 82.55' along the said southerly street line of French Street, to the point and place of beginning.
Said parcel contains 25,515 Square Feet or 0.59 Acres.

**Schedule 6.12(b)**

**Leased Real Property**

1. The property known as the Scovill Medical Center and located at 133 Scovill Street, Suite 206, Waterbury, Connecticut, and which was subject to the lease by and between Paolo Mapelli and Saint Mary's Hospital, Inc. dated January 1, 2006, as modified by the Lease Modification Agreement, dated January 1, 2009, is now owned by Saint Mary's Hospital, Inc.

**Schedule 6.14(a)**

**Legal Proceedings**

The following matters disclosed in the initial Disclosure Schedules have all been settled:

***Don Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***
***Brian Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***
***George Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***
***Patrick Doe v. The Hartford Roman Catholic Diocesan Corp., et al.***

**Schedule 6.14(b)**

**Governmental Orders**

No updates.

**Schedule 6.15(a)**

**Compliance with Laws**

[redacted]

[redacted]

[redacted]

**Schedule 6.16(a)**

**Medicare - Plans of Correction**

No updates.

**Schedule 6.16(b)**

**Medicare - Claims**

- As of June 22, 2016, 454 Medicaid accounts were rebilled based on observation claims billed in excess of 24 hours. The total amount rebilled was $757,907.32. Notice of rebilling was placed in affected patient accounts. This matter is now closed.

- November 24, 2015 - Letter received from the State of Connecticut, Department of Social Services Office of Quality Assurance – Audit Division - Draft Results from FMG audit. A draft report was received covering DSS's audit of Medicaid claims paid to Franklin Medical Group during the period January 1, 2011 through December 31, 2013. The total of the proposed audit disallowances was $1,784,454. Additional documentation was provided and an exit interview was held. The final report was received on April 22, 2016. The overpayment due to DSS is $1,224,182. An appeal letter has been sent requesting a hearing.

**Schedule 6.16(d)**

**Medicare - Accreditation Surveys/Deficiency Lists**

No updates.

**Schedule 6.19**

**HIPAA - Breach Notifications**

- **February 10, 2016** - Saint Mary's reported a breach affecting approximately 33 individuals. On December 3, 2015, a contracted courier picked up a locked, secured bag containing 33 medical records from an outpatient center to bring to the hospital. During an intermediate stop, the courier's car, along with the bag containing the records, was stolen. The vehicle was recovered on December 7, 2015 but the records were not in the vehicle and were not recorded. Affected individuals were notified starting on December 4, 2015

**Schedule 6.20**

**Affiliate Transactions**

No updates.

**Schedule 6.21(e)**

**Environmental**

The following environmental reports came into the possession of Saint Mary's subsequent to the Signing Date:

1. Limited Asbestos Inspection - Kenny Building, 1st Floor Rooms K1-101 & K1-105, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated September 30, 2015

2. Limited Asbestos Inspection - Lawlor Building, Second Floor, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated October 12, 2015

3. Limited Suspect Asbestos Inspection and Bulk Sampling - O'Brien Building, 56 Franklin Street, Waterbury, CT, performed by Fuss & O'Neill, dated January 22, 2016

4. Fire Pump Performance Inspection Report, performed by Mack Fire Protection, dated June 30, 2015

5. Certified Test, Adjust and Balance Report, performed by Air Balancing Service Co., dated June 22, 2015

6. Medical Gas System Inspection & Safety Survey, performed by Praxair Healthcare Services, dated March 10, 2016.

**Schedule 6.22**

**Employee Benefit Matters**

6.22(a)

1. Management Time Off Policy
2. Accrued Time-Off Benefits
3. HSA Plan
4. High Deductible Plan
5. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Kenneth Walker, dated March 6, 2015.
6. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Carrie Fuller-McMahon, dated August 17, 2015.
7. Wellness Plan

To the knowledge of Saint Mary's, with the exception of plan documents relating to the HSA and High Deductible plans, all documents required to be disclosed pursuant to the second paragraph of 6.22(a) have been provided to Trinity Health. The plan documents relating to the HSA and High Deductible plans have not been prepared to date.

6.22(b)

The current determination letter for the 401(k) Plan, dated January 18, 2012, is conditioned upon the timely execution of certain amendments. Exact evidence of the timely execution of these amendments has not been provided.

6.22(c)

No updates.

6.22(d)

No updates.

6.22(e)

No updates.

6.22(f)

Policy and procedures to comply with the HIPAA privacy and security regulations have not been specifically adopted for group health plans.

6.22(g)

1. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Kenneth Walker, dated March 6, 2015

2. Non-Competition and Severance Agreement for a Corporate Director by and between Saint Mary's Hospital, Inc. and Carrie Fuller-McMahon, dated August 17, 2015.

6.22(h)

No updates.

6.22(k)

No amendments have been made to non-competition and severance agreements for purposes of complying with Section 409A.

**Schedule 6.23**

**Employment Matters**

No updates.

**Schedule 6.24**

**Taxes**

No updates.

**Schedule 6.25**

**Insurance**

[6.25(i) requires a true and complete list of all current insurance policies - this is unchanged since signature date and thus no updates are required. 6.25(ii) requires a list of all pending claims and the claims history related to SMH for the 10 year period prior to Signature Date and thus does not need to be updated. However, an updated list of pending claims has been provided to NE-RHM and Trinity Health.]

**Schedule 7.04**

**Conflicts - Trinity Health and NE-RHM**

No updates.

**Schedule 7.08(a)**

**Compliance with Laws - NE-RHM**

On August 24, 2015, the State of Connecticut Department of Social Services, Office of Quality Assurance, Audit Division ("DSS") sent a letter to Saint Francis Hospital and Medical Center ("SFHMC") with findings of a claim review with dates of service July 1, 2011 through June 30, 2014 in which co-insurance or deductibles were paid to SFHMC. According to the letter the payment due DSS is $993,559. The letter was incorrectly addressed and was not delivered to SFHMC until September 8, 2015. SFHMC has appealed the Medicaid findings.

On June 29, 2016 Saint Francis Medical Group ("SFMG") concluded a retrospective review of claims billed to NGS, Medicare Administrative Contractor. SFMG determined that some of the critical care E&M services should have been billed as E&M subsequent care services. The result of the findings is that a refund is required for reimbursement received by SFMG for Inpatient Critical Care services that were not billed according to CMS instructions. These findings were first identified through an operational review in an attempt to identify possible opportunities for operational improvement as a part of SFHMC and SFMG's Integrity and Compliance Program ("ICP"). SFMG put corrective actions in place. The refund to the Medicare Program as a result of this review is $281,740 for the payments received as a result of the error in submitting E&M critical care when it should have been submitted as E&M subsequent care services to NGS Medicare for payment. Due to the time elapsed and the inability to file a corrected claim, SFMG returned the overpayment to Medicare for the aforementioned errors. SFMG is in the process of refunding $101,990 to the Medicaid program as a result of this review.

On May 18, 2016 SFHMC and SFMG received a civil investigative demand subpoena from the U.S. Department of Health and Human Services, Office of Inspector General, Office of Investigations, issued pursuant to the authority provided to the Inspector General under Public Law 95-452 in regards to services rendered by licensed independent practitioners. This is in document gathering phases at this time.

**Schedule 7.09(a)**

**Medicare - Plans of Correction - NE-RHM**

In addition to those matters originally set forth on Schedule 7.09(a) to the Transfer Agreement on the Signing Date:

The Department of Public Health conducted a Complaints; Adverse Events and CMS follow up survey beginning June 13, 2016. The Department of Public Health has not yet released any findings.

**Schedule 7.09(b)**

**Medicare/Medicaid Claims - NE-RHM**

No non-routine Medicare appeals

Saint Francis Hospital and Medical Center has several Inpatient and Outpatient Medicaid rate appeals and requests for hearings, with the first rate hearing scheduled for the fall of 2016.

Additionally, SFHMC has Department of Social Services and Department of Revenue Service Petitions for Declaratory Ruling on the Hospital Tax.

**Schedule 7.12**

**HIPAA - Breach Notifications - NE-RHM**

| YEAR | Date of Occurrence | Title | Action |
|---|---|---|---|
| Reported to OCR 2/2015 | 10/24/2014 | Inappropriate Access to PHI | Employee termination: Obtained information to locate ex-husband by looking at the record for his current significant other. |
| | 9/23/2014 | Stolen Laptop | Employee counseled: Medical Necessity Documentation saved to home computer in an effort to catch up on paperwork |
| | 12/31/2013 | Stolen ED Log | Employee counseled: Report to OCR January, 2014 |
| Reported to OCR 2/2016 | 4/8/2015 | USPS Damaged Package | Patient notified. Envelopes for mailing will be mylar. |
| | 7/17/2015 | Pulmonary office staff mailed lab results for several patients to one patient | Employee counselled and office staff re-educated |
| | 10/26/2015 | Adoptive/Birth Mother Demographics | Epic build to prevent sharing of demographic information between baby and birth mother. |

**Schedule 8.08(a)**

**Insured Real Property**

The following units have been added since the Signing Date:

- Office Condominium Unit 2I (206), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3G (304), 133 Scovill Street, Waterbury CT
- Office Condominium Unit 3F (306), 133 Scovill Street, Waterbury CT

The following parcel was sold subsequent to the Signing Date:

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Said parcel contains 25,515 Square Feet or 0.59 Acres.

## Greer, Leslie

**From:** Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
**Sent:** Friday, October 28, 2016 12:17 PM
**To:** User, OHCA
**Cc:** Anthony, Robert J.
**Subject:** Submission for Condition #4 - 15-32045-CON Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England
**Attachments:** SMHCHNA_2016.pdf

Hello,

Per Condition # 4 of the Transfer of Ownership of Saint Mary's Health System, Inc. to Trinity Health Corporation and Trinity Health-New England, ***Docket #: 15-32045-CON***, attached is the recently completed 2016 Community Health Needs Assessment (CHNA). A copy of the CHNA is publically available on the Saint Mary's website at https://www.stmh.org/about/chna/. The Implementation Strategy is currently in development and will be submitted once completed.

Feel free to contact me with any questions.

Regards,

**Claudio A. Capone, FACHE**
Regional VP of Business Development and Strategic Planning

Trinity Health - New England
1000 Asylum Avenue, 4th Floor
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Office: 860-714-6165
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Trinity Health
New England

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# Saint Mary's Hospital
# Community Health Needs Assessment

Note: Approved and adopted by the Saint Mary's Hospital Board of Directors September 1, 2016

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## Executive Summary

In collaboration with the Greater Waterbury Health Improvement Partnership, Saint Mary's Hospital led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2016. 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 Community Health Needs Assessment serves as a compilation of the overall findings of each research component.

**CHNA Data Components**

- DataHaven Community Wellbeing Survey (2015)
- Healthy People 2020 Report (2014)
- The ALICE study of Financial Hardship Report (2012)
- US Center for Disease Control and Prevention
    - County Health Rankings and Roadmaps (2016)
- Saint Mary's Hospital Community Health Profile (2015)
- Hospital Implementation Plans (2013)

**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
- Obesity
- Tobacco Use
- Asthma
- Health Communications

**Documentation**

The final report of the CHNA was made public on September 30, 2016 and can be found on the Saint Mary's Hospital website (stmh.org). Paper copies are also available per request. The Saint Mary's Hospital Board of Directors approved the CHNA on September 1, 2016. An implementation plan for community health improvement activities will be created and available by February 15, 2017.

## Introduction

Saint Mary's Hospital has served the city of Waterbury since 1907, when it was founded by the Sisters of Saint Joseph of Chambery. The founding of the hospital was made possible by a generous donation by the Right Reverend Monsignor William J. Slocum. In its first year, Saint Mary's Hospital was a 120 bed facility and had a staff of 14. It is now licensed for 347 beds and employs more than 2,100 people. The mission of Saint Mary's Hospital is to provide excellent healthcare in a spiritually enriched environment to improve the health of our community. The vision of Saint Mary's Hospital is to be the leading regional healthcare provider. Saint Mary's Hospital values are:

- Integrity: Commitment to doing what is right
- Caring: Compassionate approach to addressing the healthcare needs of all people
- Accountability: Personal responsibility for the performance of Saint Mary's Health System
- Respect: Respect for the dignity, worth, and rights of others
- Excellence: Working together in pursuit of superior clinical quality and service to others

Saint Mary's Hospital serves the city of Waterbury and 17 surrounding towns. In 2016, Saint Mary's 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 Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Saint Mary's 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 Saint Mary'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.

## Community Health Needs Assessment Summary

Community Health Needs Assessments (CHNA) and implementation strategies are required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. The CHNA and implementation strategies create an important opportunity to improve the health of communities by ensuring that hospitals have the information they need to provide community benefits that meet the needs of their communities. They also provide an opportunity to improve coordination of hospital community benefits with other efforts to improve community health.

Saint Mary's Hospital published its first federal mandated CHNA in 2013 in collaboration with contracted research and consulting firm, Holleran, and The Greater Waterbury Health Improvement Partnership. The 2016 assessment will serve as a starting point for data-based goals and strategies on how to address the needs that have been identified. The health needs acknowledged by the CHNA will be integrated into a three-year community outreach plan and implementation strategy to overcome the issues. By utilizing existing resources, strengthening partnerships and creating innovative programs on both the hospital campus and within the community, Saint Mary's Hospital hopes to make a positive impact on these identified needs.

## Report on Progress since 2013 CHNA

Saint Mary's has made meaningful progress during this three-year CHNA cycle as we have opened two new urgent care centers and grown our primary care practices with over twenty new internal medicine providers. Saint Mary's now offers four urgent care centers throughout our service area offering convenient access and extended hours. We continue to offer nurse navigation services for emergency department patients, and for our cardiac program to provide education and coordinate post-acute services. We established the "Pump Club" for cardiac patients who needed additional services to attend rehab sessions and other services. Saint Mary's also established a heart rhythm program during this period, creating easier, local access to electrophysiology services that were previously not available in our community. Saint Mary's continues to support and collaborate with the Malta House of Care, which provides medical services to undocumented and indigent population. We continue to work closely with the Harold Leever Cancer Center to address smoking cessation in our community. We have hosted a series of farmers markets on the hospital campus using our community partner, Brass City Harvest. Through our work with the Greater Waterbury Health Improvement Partnership are working towards the creation of a Community Care Team to provide cross-organization case management for high utilization emergency department visitors.

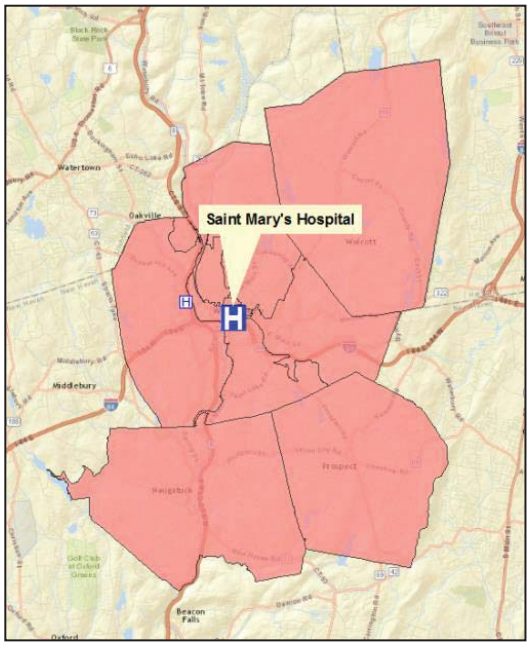
Since 2013 Saint Mary's has continued to work towards maintaining its existing programs while introducing new initiatives as appropriate. We have also continued to fully participate in the Greater Waterbury Health Improvement Partnership (GWHIP) which creates opportunities for collective impact, fosters greater collaboration community-wide, and helps make better use of resources by eliminating duplication of effort wherever possible. In August 2016 Saint Mary's joined Trinity Health, becoming a part of the Trinity Health – New England regional health ministry. Becoming part of a strong national and regional system will provide further opportunities to enhance our ability to meet the needs of our community.

## Overview of Hospital Service Area and Facilities

**Service Area**

Saint Mary's total service area is comprised of 35 zip codes, which include the city of Waterbury and 17 surrounding towns. The primary service area which covers 9 US Census zip code tabulation areas (ZCTAs) includes Waterbury, Naugatuck, Prospect and Wolcott has a population of approximately 168,000. The secondary service area includes Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Oxford, Plantsville, Plymouth, Southbury, Thomaston, Watertown and Woodbury has a population of approximately 153,000.

**Figure 1. Saint Mary's Primary Service Area Map**




2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

**Population**

The combined population for these communities is roughly 321,000 residents where the majority of Saint Mary's hospital patients live in the city of Waterbury which is particularly economically distressed. The median household income is $41,136, which is significantly less than the overall service area, which is approximately $70,000. The unemployment rate in the city of Waterbury in September 2015 was 10.7%. This is higher than the state of Connecticut unemployment rate of 6.6%. Approximately 31.6% of the population in Waterbury speaks a language other than English in the home. This is higher than the state of Connecticut where 20.8% of the population speaks a language other than English in the home. In addition, 24.2% of families in Waterbury have poverty status compared to 10.5% in Connecticut.

Central Waterbury has been designated a Medically Underserved Area (MUA) and Medically Underserved Population (MUP) by the health resources and services administration (HRSA). HRSA has also designated central Waterbury as a Health Professional Shortage Area (HPSA) for primary medical care, dental care and mental health. In Table 1. CHA Service Area Population Findings, there is a breakdown of population details provided by the US Census (2009-2013) and specifically the Primary Service Area of Saint Mary's Hospital.

**Table 1. CHA Service Area Population Findings**

| Demographic Category | Indicator | Primary Service Area Total | | Connecticut Total | |
|---|---|---|---|---|---|
| Total Population | Total Population | 168,145 | 100% | 3,583,561 | 100% |
| Age | Less than 18 Years Old | 40,417 | 24% | 802,718 | 22% |
| | Over 64 Years Old | 22,263 | 13% | 519,616 | 15% |
| Race and Ethnicity | White | 96,590 | 57% | 2,526,401 | 70% |
| | Black | 21,484 | 13% | 337,758 | 9% |
| | Hispanic | 42,329 | 25% | 496,393 | 14% |
| | Asian | 3,124 | 2% | 140,592 | 4% |
| | Other | 4,618 | 3% | 81,871 | 2% |
| Gender | Male | 81,194 | 48% | 1,745,194 | 49% |
| | Female | 86,951 | 52% | 1,838,367 | 51% |

Source: US Census (2009-2013) and primary service area determined by Connecticut Hospital Association (2015)

**Saint Mary's Facilities**

*Saint Mary's Hospital*

Saint Mary's Hospital is a Catholic, not-for-profit, community teaching hospital that has been serving patients in Waterbury, Connecticut since 1909. The hospital offers a wide variety of medical services, educational classes, and patient resources in addition to a Level II Trauma Center, pediatric emergency room, award winning cardiac and stroke care and exceptional surgical services.

*Naugatuck Valley Surgical Center*

Naugatuck Valley Surgical Center (NVSC) is an outpatient department of Saint Mary's Hospital which offers state-of-the-art operating rooms and post-operative patient care areas for ambulatory surgery. The surgical center staff is experience in a wide variety of specialties including Gastroenterology, General Surgery, Gynecology, Ophthalmology, Oral/Dental Surgery, Orthopedics , Otorhinolaryngology (ENT), Pain Management, Plastic Surgery, Podiatry and Urology

*The Harold Leever Regional Cancer Center and Saint Mary's Hospital Oncology Center*

The Harold Leever Regional Cancer Center is a joint partnership of Saint Mary's Hospital and Waterbury Hospital offering the highest quality care for cancer patients. In the building sits Saint Mary's Hospital Oncology Center which provides the most up-to-date treatment and protocols for patients right here in our community, and is located right in Waterbury, just off I-84.

*Saint Mary's Medical Imaging Center*

From X-rays, MRI and CT scans to images taken at a nuclear level, Saint Mary's is dedicated to providing advanced radiology services. Saint Mary's Medical Imaging Center is fully digital, which offers many advantages, including improved image quality and enhanced speed.

*Saint Mary's Hospital Urgent Care Centers (Cheshire, Naugatuck, Wolcott, Waterbury)*

Saint Mary's has expanded its footprint to offer four urgent care locations that provide a greater access to care for patients in the service area. The urgent care centers offer a wide array of services including x-ray, laboratory services, EKGs, immunizations and vaccines, pediatric care, and work-related injuries.

## Community Health Needs Assessment Process

Saint Mary's Hospital's 2016 CHNA is based on data and input from multiple sources.
These include:

- **DataHaven Health and Wellbeing survey**: Saint Mary's participated in this data collection effort through the Greater Waterbury Health Improvement Partnership. The survey was conducted statewide, providing a valuable data set across multiple communities. A separate report was developed focusing on the Waterbury community.
- **GWHIP Steering Committee Strategic Review**: the founding partners of the Greater Waterbury Health Improvement Partnership met to review our collective experience and insights from 2013-2016. We discussed the performance of the various workgroups, initiatives implemented, and the expected impact. Based on this assessment several changes were recommended.
- **CDC Learning Cohort**: Waterbury was one of thirteen communities in the country selected to participate in this learning opportunity**.** The learning cohort offered access to best practices, insight into what's worked in other communities, and specific coaching
- **Trinity Health Community Health & Well Being**: As Saint Mary's prepared to become a member of Trinity Health, we were afforded the opportunity to have discussions with colleagues from Hartford as well as the system office in Lavonia, Michigan. These discussions, although preliminary in nature, have begun to shape our planning process. We expect that we will gain further benefit as we move ahead once fully integrated in to the Trinity Health regional health ministry.

Each of these inputs contributed a unique perspective to the overall plan.
Additional inputs and resources are listed below.

**Community Primary Data Sets**
**Community Programming Surveys**
The data was gathered from information residents who attended Saint Mary's Hospital's community outreach programs specifically with the Spirit of Women Network. This came in the form of post-event surveys and verbal conversations.

**Community Leader Discussions/Executive Meeting**
In addition to gathering quantitative data, Saint Mary's obtained input from important community stakeholders regarding the health needs of the community. Interviews and informal discussions with community leaders in the Greater Waterbury area were also used to expand the knowledge of the issues affecting the service area. Some if not most of the community leaders that were involved in discussions grew up in the area and represented broad interests in our community including: leaders of medically underserved and low-income populations, persons with expertise or special knowledge in public health, and persons who lead local health agencies. In addition, a comprehensive community executive meeting was held in June 2016 and informal discussions with key informants in regards to Saint Mary's service area were completed.

**Community Health Needs Assessment Data Sets**
The following data sets were used and analyzed in order to obtain secondary data for Saint Mary's 2016 CHNA.

**The ALICE Study of Financial Hardship Report**
In 2012, the United Way completed a report titled ALICE (Asset Limited, Income Constrained, and Employed) which represented the growing number of individuals and families who are working, but are unable to afford the basic necessities such as housing, food, child care, health care, and transportation.

**State of Connecticut**
The official website of the State of Connecticut (ct.gov). Several resources were used from the State of Connecticut's website primarily regarding education and public health datasets for the purposes of expanding the information in this CHNA.

**US Center for Disease Control and Prevention**
As the leader in the nation's public health concerns, the US Center for Disease Control and Prevention (CDC) provides insights and data on diseases, chronic to acute and curable to preventable.

**County Health Rankings and Roadmaps (2016)**
These are the data measures adopted by the Centers for Disease Control (CDC) as standard measures of community health by which to assess the nation's health and allows comparisons at national, state and local levels. They have been selected based on their relevance as indices of community health and their general availability for assessments at all levels. The information for this data can be found in Appendix 1 and is often referred to in this CHNA.

**Healthy People 2020 (2014)**
Healthy People 2020 was developed by the Office of Disease Prevention and Health Promotion to assist in creating societies of residents living long and healthy lives and specifically offers state-by-state data.

**Saint Mary's Hospital Community Health Profile (2015)**
The Saint Mary's Hospital Community Health Profile (2015) was provided by the Connecticut Hospital Association(CHA). Completed each year by CHA, the document provides data and support for Connecticut hospitals and their community partners particularly with the Community Health Needs Assessment. Within this community profile, data was used from CHA's ChimeData database, US Census, the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS), the Connecticut Department of Public Health, and several other sources.

**The 2015 DataHaven Community Health and Wellbeing Survey**
The public service organization, DataHaven, completed the DataHaven Community Health and Wellbeing Survey in 2015 as a grassroots and locally based effort to promote regional well-being and quality of life. Using telephone surveys, the company was able to receive data from nearly 17,000 residents of Connecticut of which 610 were surveyed from the City of Waterbury. The information from the survey was heavily used in this CHNA and provided necessary information for prioritization for Saint Mary's.

**Research Limitations**
It should be noted that the availability of secondary data may represent some research limitations.

## Community Health Needs Assessment Findings

Saint Mary's utilized the "Invest in Your Community: 4 Considerations to Improve Health and Wellbeing for All" and the "County Health Rankings Model - Health Factors" as guide and framework for its work. The Centers for Disease Control and Prevention (CDC) created a detailed outline which has been used as the core of the Greater Waterbury Health Improvement Partnership it can be found on page 24 of this CHNA.

Using the CDC's graphic as a model, Saint Mary's focused on the four elements of good health:

- Socioeconomic Factors, which accounts for 40%
- Physical Environment, which accounts for 10%
- Health Behaviors, which account for 30%
- Clinical Care, which accounts for 20%

### Socioeconomic Factors

Socioeconomic factors have the largest impact on one's health according the CDC model of community health and wellbeing accounting for 40% in the described model. Socioeconomic factors that affect good health include a combination of: education, employment, income, and community support. These factors are known as the "social determinants" of health.

**Employment & Income**

According to the 2012 ALICE (Asset Limited Income Constrained Employment) Report, the state of Connecticut had a poverty rate of 10% and a median household income of $67,276. These numbers compare well to the U.S. average poverty rate of 15%, and the median household income in U.S. of $51,371. When looking specifically at the city of Waterbury, one of Connecticut's largest cities the report showed that out of 40,992 households, 23% of the residents were living in poverty and an added 34% fell under the ALICE characterization totaling over 50% of households below the ALICE threshold. Additional information can be seen in Table 2. in regards to the ALICE Report.

**Table 2. Key Facts and ALICE Statistics by Municipality, Connecticut, 2012**

| Municipality | Waterbury, New Haven County |
|---|---|
| Population | 109,915 |
| Households | 40,992 |
| Poverty % | 23% |
| ALICE % | 34% |
| Above ALICE Threshold % | 43% |
| Gini Coefficient | 0.45 |
| Unemployment Rate | 13% |
| Health Insurance Coverage % | 86% |
| Housing Burden: Owner over 30% | 42% |
| Housing Burden: Renter over 30% | 60% |

Source: United Way ALICE Report; American Community Survey

Saint Mary's primary and secondary service area as mentioned above encompasses 35 zip codes and 17 towns. On page 11, The ALICE and Poverty Rates by Towns can be seen in Table 3 and include information with the total households and the total % of ALICE and Poverty households pertaining to the specific town.

**Table 3. ALICE and Poverty Rates by Town, 2012**

| Town | Total Households | % ALICE and Poverty |
|---|---|---|
| Beacon Falls | 2,244 | 26% |
| Bethlehem | 1,409 | 17% |
| Cheshire | 9,641 | 15% |
| Middlebury | 2,797 | 20% |
| Morris | 967 | 27% |
| Naugatuck | 12,588 | 40% |
| Oxford | 4,420 | 13% |
| Plymouth | 4,739 | 24% |
| Prospect | 3,280 | 19% |
| Southbury | 8,022 | 31% |
| Thomaston | 3,192 | 27% |
| Waterbury | 40,992 | 57% |
| Watertown | 8,270 | 25% |
| Wolcott | 5,947 | 23% |
| Woodbury | 4,204 | 24% |

Source: United Way ALICE Report, U.S. Department of Housing and Urban Development (HUD), U.S. Department of Agriculture (USDA), Bureau of Labor Statistics (BLS), Internal Revenue Service (IRS) and state Treasury, and ChildCare Aware, 2012; American Community Survey, 1 year estimate.
*Note: Plantsville, Connecticut (zip code: 06479) was not included in the service areas reported

**Education**

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. According to the U.S. Census Bureau, High school and higher education graduation rates are lower in Waterbury (79.6% and 16.0% respectively) than in Connecticut (86.3% and 29.3% respectively).

According to the County Health Rankings in Saint Mary's service area counties the percentage of students who graduate High School in four years from New Haven County is 81%, from Litchfield County is 89%, and Hartford County is 82%. As seen below in Table 4. in Saint Mary's Service area covered by the Connecticut Hospital Association, 20% of the residents have a Bachelor's Degree or higher, whereas 36% of the State of Connecticut hold such education.

**Table 4. Socioeconomic Data by CHA Primary Service Area**

| Demographic Category | Indicator | Primary Service Area Total | | Connecticut Total | |
|---|---|---|---|---|---|
| Socioeconomics | Below Poverty | 29,226 | 18% | 354,348 | 10% |
| | Bachelor's Degree or Higher | 22,198 | 20% | 886,514 | 36% |

Source: US Census (2009-2013); primary service area determined by Connecticut Hospital Association (2015)

In recent reports from the 2013-2014 Connecticut Department of Education Chronic Absenteeism Report, Waterbury Public Schools are on the top of the list for chronic absenteeism in the district. Over 20% of students in the district fall into the category of chronically absent from school which is defined as any student with a calculated Average Daily Attendance (ADA) of less than or equal to 90%. This number was significantly higher when looking at chronic absenteeism in the Waterbury Public High School rates which were at 33.7% among the highest in the state of Connecticut.

**Neighborhood and Community Safety**

One of the most significant social determinants of health is the conditions in which residents have a sense of security and community within their geographic location. In order to better understand overall safety in the community in three different levels, data was taken from overall Connecticut respondents, Greater Waterbury and Waterbury. Within that data table below, one can see that overall the results for satisfaction with Greater Waterbury was 78% and in the city of Waterbury was 63%.

**Table 5. Neighborhood Satisfaction**

Are you satisfied with the city or area where you live?

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Yes | 82% | 78% | 63% |
| No | 17% | 22% | 36% |
| Don't Know | 1% | 1% | 1% |
| Refused | 0% | 0% | 0% |

Source: DataHaven Health and Wellbeing Survey

While the overall satisfaction in Greater Waterbury and Waterbury are less than the Connecticut average ranking quite high at 82%, the responses for the safety of residents in their neighborhood merits further examination which can be seen below at staggering rates below the Connecticut's average.

**Table 6. Residents Safety**

The job done by the police to keep residents safe…

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Excellent | 30% | 30% | 15% |
| Good | 45% | 41% | 35% |
| Fair | 15% | 16% | 28% |
| Poor | 6% | 9% | 16% |
| Don't know enough about it in order to say | 4% | 3% | 5% |
| Refused | 0% | 0% | 0% |

Source: DataHaven Health and Wellbeing Survey

**Table 7. Neighborhood Responses**

The information below portrays the percentage of respondents that stated that they "strongly agreed" with the specific questions asked in the DataHaven Health and Wellbeing Survey.

| Questions answered with "Strongly Agree" | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| There are safe sidewalks and crosswalks on most of the streets in my neighborhood. | 39% | 32% | 39% |
| I do not feel safe to go on walks in my neighborhood at night. | 16% | 18% | 29% |
| People in my neighborhood can be trusted. | 54% | 55% | 33% |
| Children and youth in my town generally have the positive role models they need around here. | 38% | 38% | 17% |

Source: DataHaven Health and Wellbeing Survey

**Transportation**

Comparable to state average, the Greater Waterbury service area residents have access to a car or have their own car as the primary means of transportation as seen in Table 8. Public transportation is available in this city of Waterbury and immediate suburban towns but only 8% of respondents in the DataHaven survey said to use it. With a 12% response, most residents in Waterbury would be more apt to get a ride from a friend or relative than to use public transportation as a primary means of transportation.

**Table 8. Access to Car**

Do you have access to a car when you need it? Would you say you have access…

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Very often | 85% | 83% | 74% |
| Fairly often | 4% | 5% | 4% |
| Sometimes | 5% | 5% | 8% |
| Almost never | 1% | 1% | 3% |
| Never at all | 5% | 6% | 11% |
| Don't Know | 0% | 0% | 0% |

Source: DataHaven Health and Wellbeing Survey

## Physical Environment

According to the CDC model, where you live is one of the greatest predictors of how healthy you will be and accounts for 10% in the "Invest in Your Community" Model. Living in a safe neighborhood that has adequate environmental factors can lead to higher rates in overall wellbeing.

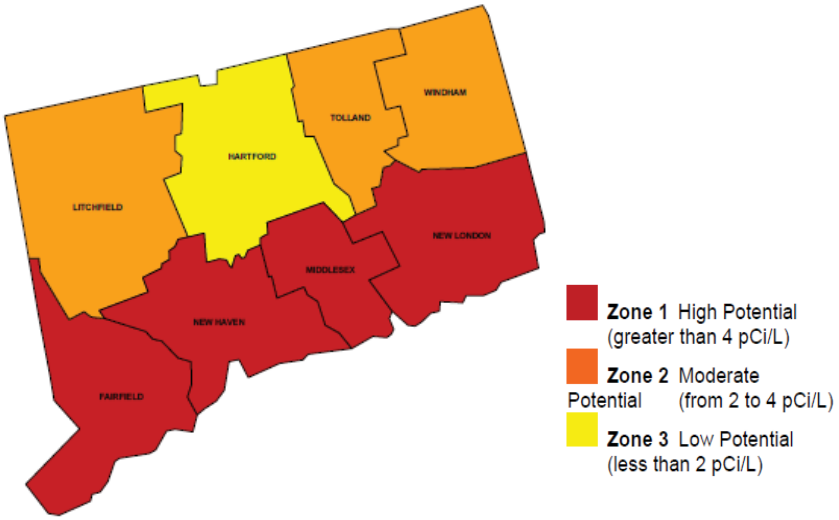
### Air Quality

Air Quality Index AQI is a number used by government agencies to communicate to the public how polluted the air is currently or how polluted it is forecast to become. As the AQI increases, an increasingly large percentage of the population is likely to experience increasingly severe adverse health effects including asthma and cardiovascular disease. According to the U.S. Environmental Protection Agency in 2013 the Air Quality Index (AQI) was significantly worse in the city of Waterbury at 106 compared to the United States Index average of 75.

### Radon Zones

According to the U.S. Environmental Protection Agency, New Haven County, which occupies Saint Mary's Hospital service area, falls within the EPA's Radon Zone 1 indicating a High Potential for radon exposure for that service area community. As stated by the World Health Organization, radon is the second most important cause of lung cancer in many countries and lung cancer risk rises 16% per 2.7 pCi/L increase in radon exposure.

**Figure 2. Map of Radon Zones in Connecticut**




Source: US EPA (2013); primary service area determined by Connecticut Hospital Association (2015)

### Housing

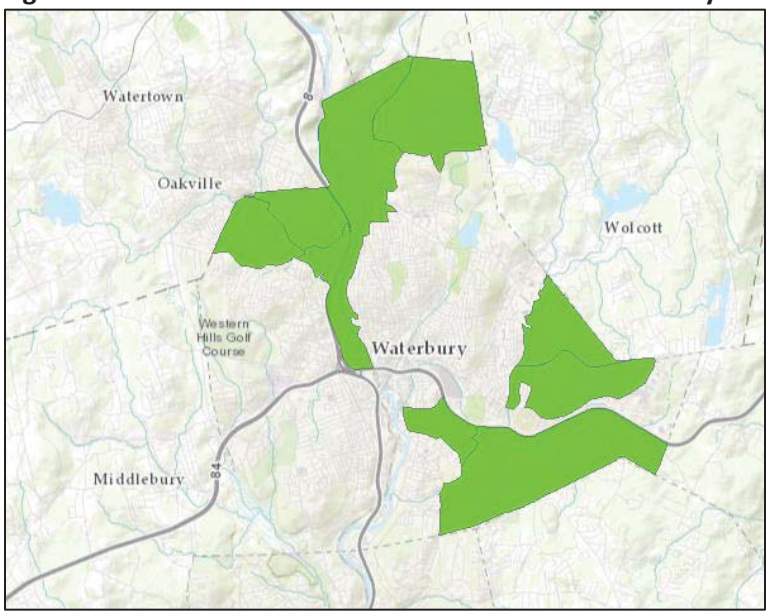
Housing insecurity is an issue that continues to impact Saint Mary's service area residents. Over a third of the population in Saint Mary's service area is housing cost burdened, with rates close to 35% in Waterbury (U.S. Census Bureau, 2010-2014). According to the US Census Bureau, housing cost burden is defined as more than 30% of income going towards housing expenses. A lack of affordable housing can contribute to many factors including homelessness and housing instability and insecurity.

## Health Behaviors

The third factor to be discussed is health behaviors that account for 30% of the "Invest In Your Community" Model. This category includes topics such as diet, exercise, and substance use. These can also be defined as daily routines that residents in a community have that play a role in their overall health and wellbeing.

**Diet and Exercise**

**Figure 3. USDA Food Atlas Food Desert Areas in Waterbury**




Source: USDA Food Access Research Atlas; accessed 8/17/16

The USDA Food Access Research Atlas identifies low income and low access census tracts in order to greater understand the ability for members of the population to have access to a supermarket for nourishing and healthy food options. Places which have a great distance to a supermarket is known as a food desert. As seen in Figure 3 in green, Waterbury has several identified areas that are considered food deserts.

**Table 9. Weekly Exercise**

In an average week, how many days per week do you exercise?

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| None | 17% | 20% | 26% |
| One | 6% | 5% | 6% |
| Two | 13% | 10% | 10% |
| Three | 19% | 20% | 17% |
| Four | 12% | 10% | 8% |
| Five | 12% | 12% | 12% |
| Six | 5% | 4% | 2% |
| Seven | 16% | 17% | 17% |
| Don't Know | 1% | 1% | 1% |
| Refused | 1% | 1% | 1% |

Source: DataHaven Health and Wellbeing Survey

**Table 10. Body Mass Index**
**BMI (Based on Q24 Weight and Q25 Height DataHaven Survey)**

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Underweight | 2% | 2% | 2% |
| Normal weight | 37% | 33% | 27% |
| Overweight | 36% | 37% | 37% |
| Obese | 26% | 28% | 33% |

Source: DataHaven Health and Wellbeing Survey

**Alcohol and Substance Use**

Substance use in the state of Connecticut and specifically in the city of Waterbury has been a large public health concern with the rising rates overdose cases. As one of the top five conditions for Saint Mary's Emergency Department non-admission rates, substance use and abuse remains a problem in particular with prescription and opioid based medications.

**Tobacco Use**

Tobacco use is a major concern in Waterbury especially with the number of residents who currently smoke on a daily basis. According to the DataHaven Health and WellBeing Survey 45.0% of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 40.0% across the state. In addition, more than half (55.0%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (37.0%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months by not smoking for 24 hours or more.

**Table 11. Current Tobacco Use**
**(If smoked 100 cigarettes in entire life) Do you currently smoke cigarettes every day, some days or not at all?**

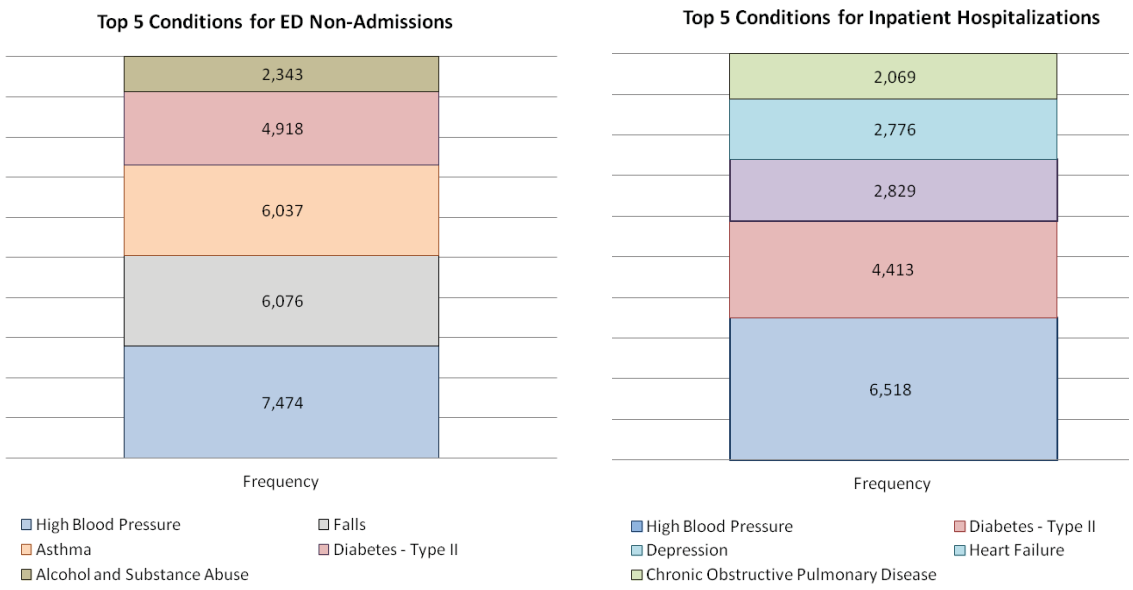
| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Every day | 26% | 29% | 40% |
| Some days | 11% | 11% | 15% |
| Not at all | 63% | 60% | 45% |
| Don't know | 0% | 0% | 0% |
| Refused | 0% | 0% | 0% |
| Smoking Prevalence (based on several questions in DataHaven Survey) | 15% | 17% | 25% |

Source: DataHaven Health and Wellbeing Survey

## Clinical Care

The last factor that is mentioned in the CDC model is clinical care, which accounts for 20% of good health. To better understand this for Saint Mary's primary service area several data sets have been used from the Connecticut Hospital Association in order to better understand the access to care as well as the quality of care given to patients.

**Figure 4. Inpatient Hospitalizations and Conditions for ED Non-Admissions**

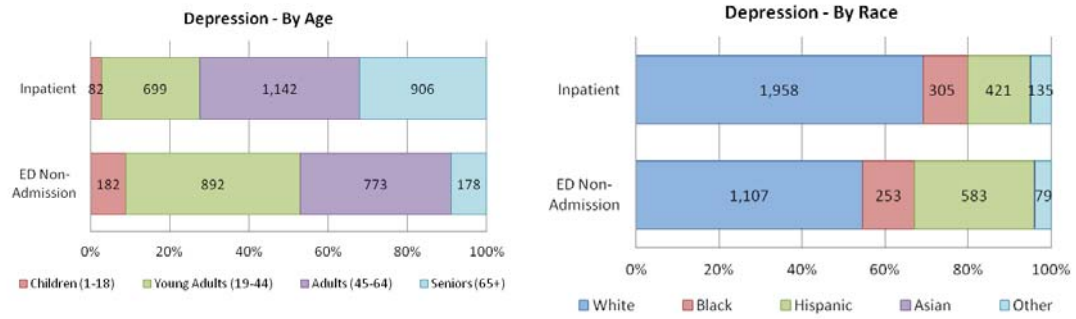



Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

*Mental Health*

Mental and Behavioral Health continue to have a dramatic impact on the overall health of residents in the Saint Mary's service area. Feeling physically unwell can impact a person's emotional wellbeing and if not taken seriously can lead to depression and anxiety. As seen in the figures below, the largest group of patients at Saint Mary's were white adults age 45 to 64 according to the 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association.

**Figure 5. Depression by Age and Race**



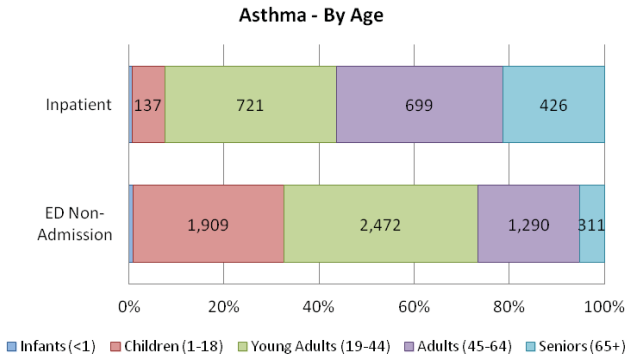

Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

In addition to depression, suicide and self-inflicted injuries were an increasing health concern for the hospital with 243 ED non-admission patients of which 142 were insured with Medicaid (Connecticut Hospital Association, 2015).

*Asthma*

In Greater Waterbury there are fare to many area children and adults that have poorly managed asthma which results in significant amounts of emergency department visits and potential inpatient admissions. Both pediatric and adult asthmatics have potential gaps in the education of management of asthma and its potential life threating symptoms. Despite being in line with the Connecticut average of respondents having Asthma in the Greater Waterbury Area and City of Waterbury, of the respondents that answered "yes" to having Asthma the rate was double the Connecticut average at (12% and 16% respectively) for having an Asthma attack at least once a day and using a prescription inhaler (DataHaven Health and Wellbeing Survey, 2015).

**Figure 6. Asthma by Age**




Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

*Oral Health*

According to the American Dental Association, most dental Emergency Room visits can be reduced or eliminated by regular visits to a dentist. In the DataHaven Health and Wellbeing Survey, almost 1 in 3 residents of Waterbury reported not have been to a dentist for more than a year (2015). In addition, Emergency Department visits for dental conditions were proportionally overrepresented among blacks and Hispanics in Saint Mary's service area.

*Cancer*

Cancer affects Waterbury residents at an (age-adjusted) rate of 491.1 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 491.1 is similar to or lower than that of peer cities such as Hartford and New Haven which can be seen in Table 13.

**Table 12. Cancer Incidence in Waterbury per 100,000 (2010)**

| Primary Cancer Site | Crude Rate | Age-Adjusted Rate |
|---|---|---|
| Breast (Female) | 139.0 | 128.9 |
| Colorectal* | 60.0 | 57.6 |
| Lung & Bronchus* | 77.4 | 74.8 |
| Prostate | 115.4 | 120.8 |
| All sites | 506.3 | 491.1 |

Source: Connecticut Tumor Registry, Health Statistics & Surveillance Section, CT Department of Public Health
*Denotes that State-Town Comparison rates are higher than the state rate.

**Table 13. Cancer Incidence by City per 100,000 (2010)**

| | Connecticut | Waterbury | Hartford | New Haven |
|---|---|---|---|---|
| All sites (Age-adjusted) | 489.3 | 491.1 | 472.5 | 515.9 |

Source: Connecticut Tumor Registry, Health Statistics & Surveillance Section, CT Department of Public Health

The mortality rate per 100,000 for all cancer types is 146.7 in Connecticut which is surpassing the Healthy People 2020 target of 161.4 (2014).

**Table 14. Overall Cancer Deaths by Total in Connecticut**

| | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| Total* | 163.4 | 158.4 | 151.9 | 148.4 | 146.7 |

Source: Healthy People 2020 (2014), State-Level Data: Connecticut
*Total (Age adjusted, per 100,000 population)

*Diabetes*

Not only in the Saint Mary's service area and the state of Connecticut has diabetes been a major health concern but across the United States. According to the Center for Disease Control, 29 million Americans have diabetes and 86 million American adults aged 20 years and older have prediabetes. As seen below, residents in Waterbury have been told by a doctor more frequently that they have diabetes than in the Greater Waterbury area and in Connecticut. The unease with this number is that residents that have diabetes are at higher risk for serious health complications including: blindness, kidney failure, heart disease, stroke, and potential loss of extremities.

**Table 15. Have you ever been told by a doctor or health professional that you have diabetes?**

| Connecticut | Greater Waterbury | Waterbury |
|---|---|---|
| 9%* | 11%* | 13%* |

Source: DataHaven Health and Wellbeing Survey
*percentage of respondents that answered yes

*Cardiovascular Disease*

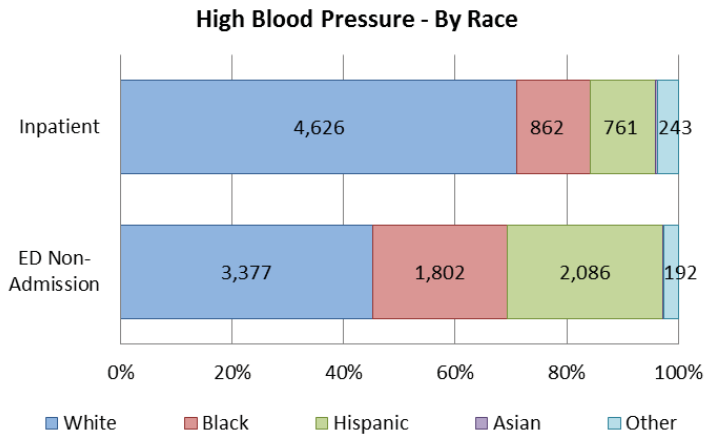
According to the Connecticut Hospital Association, high blood pressure was the most prevalent condition among inpatient and Emergency Department Non-Admission settings. A total of 35% of residents in Waterbury responded "yes" to having been told by their doctor or health professional that they had high blood pressure or hypertension which are contributing factors to (other than obesity and lack of physical exercise) to more serious cardiovascular disease.

**Table 16. Have you ever been told by a doctor or health professional you have high blood pressure or hypertension?**

| Connecticut | Greater Waterbury | Waterbury |
|---|---|---|
| 28%* | 32%* | 35%* |

Source: DataHaven Health and Wellbeing Survey
*percentage of respondents that answered yes

**Figure 7. High Blood Pressure by Race**




Source: 2015 Saint Mary's Hospital Community Health Profile, Connecticut Hospital Association

**Barriers to Care**

Access to care remains one of the top concerns for Saint Mary's and its patients in the community. The tables below report access to services, insurance and prescription medications from the DataHaven Health and Wellbeing Survey.

**Table 17. During the past 12 months, was there any time when you didn't get the medical care you needed?**

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Yes | 7% | 9% | 10% |
| No | 92% | 91% | 89% |
| Don't know | 0% | 0% | 0% |
| Refused | 0% | 0% | 1% |

Source: DataHaven Health and Wellbeing Survey

**Table 18. And was there any time during the past 12 months when you put off or postponed getting medical care you thought you needed?**

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Yes | 21% | 20% | 22% |
| No | 79% | 80% | 77% |
| Don't know | 0% | 0% | 0% |
| Refused | 1% | 0% | 0% |

Source: DataHaven Health and Wellbeing Survey

**Table 19. If postponed or medical care not given, what was the reasoning?**

| | Connecticut | Greater Waterbury | Waterbury |
|---|---|---|---|
| Cost | 49% | 45% | 45% |
| Health insurance was not accepted (Doctor's office or Hospital) | 16% | 12% | 14% |
| Health insurance did not cover treatment | 28% | 33% | 35% |
| Appointment was not in a reasonable amount of time | 25% | 27% | 30% |
| The medical problem did not seem serious enough | 46% | 43% | 39% |

Source: DataHaven Health and Wellbeing Survey

## Strategies to Address Community Health Needs

**Selection of the Community Health Priorities and Future Planning**

In May 2016, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the GWHIP data and planning for the future. The meeting was initiated by partners of the Greater Waterbury Health Improvement Partnership, including Saint Mary's Hospital. The goal of the meeting was to discuss the commitment to the Greater Waterbury area and discuss future prioritizations of the organization and its members.

The objectives of the session were:

- To review recently compiled DataHaven Community Health and Wellbeing data and highlight key research findings;
- To gather feedback from community representatives about community health needs;
- To prioritize the community health needs based on select criteria.

*Prioritization Process*

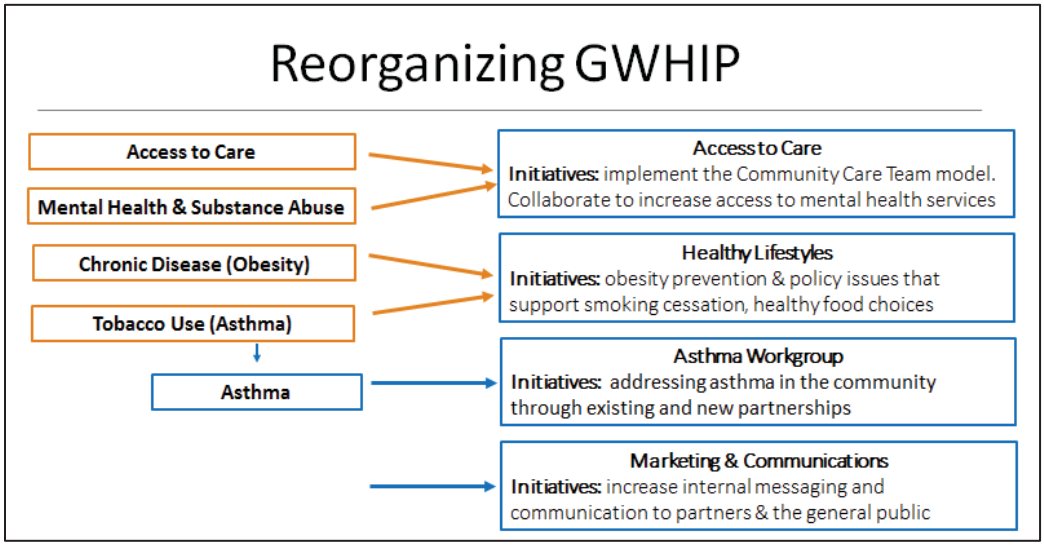
Executive leaders of the Connecticut Community Foundation, City of Waterbury Health Department, and Greater Waterbury Health Improvement Partnership facilitated the prioritization session. The meeting began with an abbreviated research overview, including the results of the primary and secondary research and key findings of the CHNA.

Following the research overview of the DataHaven Health and Wellbeing Data, meeting participants were provided with information regarding the prioritization process, criteria to consider moving forward with key areas of focus, and other aspects of health improvement planning. In a large-group format, attendees were asked to share openly what they perceived to be the needs and areas of opportunity in the community and how they would fit into the prioritization areas.

**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 in order to touch on several health initiatives:

**Figure 8. Reorganization of Greater Waterbury Health Improvement Partnership**



**Strategies to Address Community Health Needs**

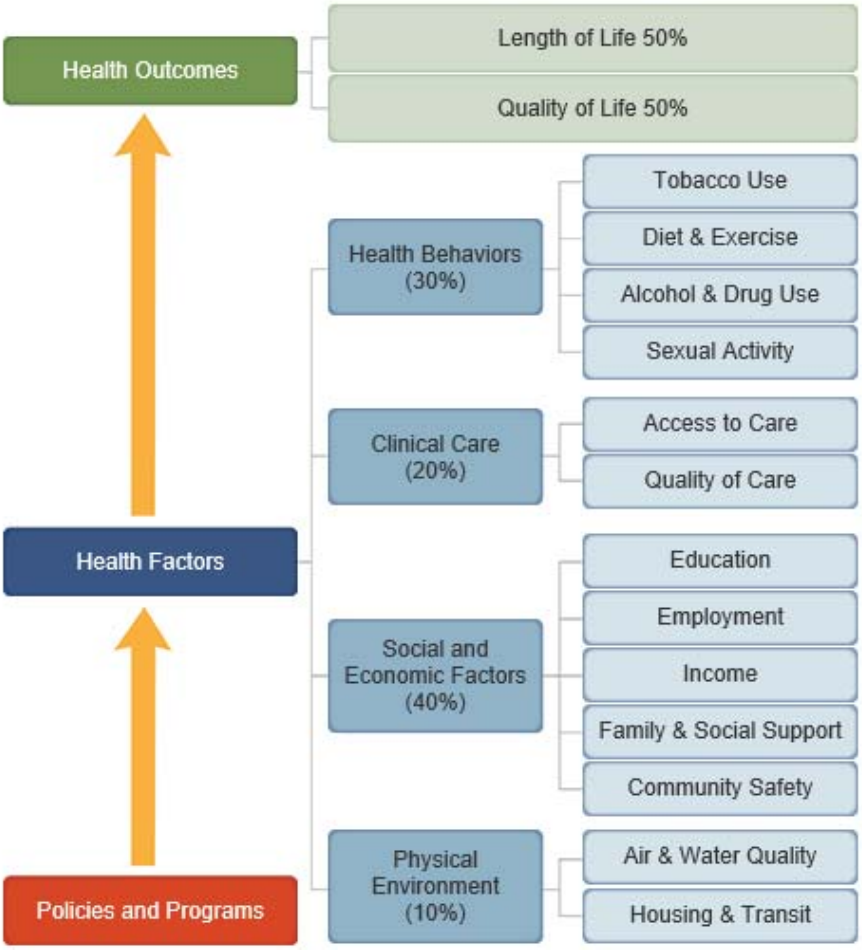
Saint Mary's Hospital will develop an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work will be completed by February 15, 2017 is supported by community-wide efforts and leadership from the executive team and board of directors.

**Rationale for Community Health Needs Not Addressed**

Saint Mary's Hospital plans to address all of the prioritized community health needs identified through the 2016 Community Health Needs Assessment and prioritized by community representatives.

## Invest in Your Community Template

## County Health Rankings Model - Health Factors



# Appendices

## Appendix 1. Community Health Rankings

Saint Mary's Hospital County Health Rankings

Health Outcomes Rank of 6 (out of 8 counties)

Health Factors Rank of 7 (out of 8 counties)

| Measures | New Haven County | Litchfield County | Hartford County | State |
|---|---|---|---|---|
| ***Health Outcomes*** | | | | |
| *Length of Life* | | | | |
| Premature death /100,000 | 5800 | 5500 | 5700 | 5300 |
| *Quality of Life* | | | | |
| % Adults reporting fair or poor health | 13% | 9% | 13% | 14% |
| Avg. physically unhealthy days/month | 2.9 | 2.5 | 3.1 | 3.2 |
| Avg. mentally unhealthy days/month | 3.5 | 3.2 | 3.4 | 3.7 |
| % Live births with low birth weight <2500g | 8% | 7% | 9% | 8% |
| ***Health Factors*** | | | | |
| *Health Behaviors* | | | | |
| % Adults report currently smoking cigarettes | 14% | 13% | 13% | 15% |
| % Adults reporting BMI >= 30 | 26% | 23% | 27% | 25% |
| Food environment index | 7.6 | 8.5 | 7.7 | 7.9 |
| % Adults 20+ reporting no leisure-time physical activity | 23% | 21% | 23% | 22% |
| % Pop. with adequate access to locations for physical activity | 96% | 90% | 96% | 94% |
| % Adults reporting binge drinking | 16% | 19% | 17% | 18% |
| % Alcohol-impaired driving deaths | 28% | 28% | 37% | 33% |
| Chlamydia rate /100,000 | 440.3 | 174.4 | 418.9 | 355.8 |
| Teen birth rate /1,000 female pop., ages 15-19 | 22 | 11 | 24 | 19 |
| *Clinical Care* | | | | |
| % Pop. under age 65 without health | 11% | 10% | 10% | 11% |
| Ratio of pop. to primary care physicians | 1060: 1 | 1570: 1 | 1070: 1 | 1170: 1 |
| Ratio of pop. to dentists | 1360: 1 | 1650: 1 | 1000: 1 | 1230: 1 |
| Ratio of pop. to mental health providers | 270: 1 | 490: 1 | 230: 1 | 300: 1 |
| Preventable hospital stays /1,000 Medicare | 53 | 49 | 51 | 50 |
| % Diabetic Medicare enrollees receiving | 85% | 88% | 87% | 86% |
| % Female Medicare enrollees receiving mammography | 65% | 65% | 68% | 67% |
| *Social & Economic Factors* | | | | |
| % Students who graduate HS in 4 years | 81% | 89% | 82% | 86% |
| % Adults, age 25-44 with some college | 65% | 66% | 68% | 68% |
| % Pop. age 16+ unemployed but seeking work | 7.2% | 5.9% | 6.9% | 6.6% |
| % Under age 18 in poverty | 18% | 9% | 18% | 15% |
| % Adults without social/emotional support | N/A | N/A | N/A | N/A |
| % Children in single parent households | 36% | 21% | 37% | 31% |
| Violent crime /100,000 | 406 | 111 | 323 | 279 |
| Injury mortality /100,000 | 57 | 57 | 56 | 53 |
| *Physical Environment* | | | | |
| Avg. daily fine particulate matter in micrograms/cubic meter (PM2.5) | 10.5 | 10.7 | 10.5 | 10.5 |
| % Pop. potentially exposed to water exceeding a violation limit /yr | N/A | N/A | N/A | N/A |
| % Households with severe housing problems | 22% | 16% | 18% | 19% |
| % Workforce driving alone to work | 79% | 83% | 81% | 79% |
| % Commuting 30+ mins to work, driving alone | 32% | 38% | 27% | 32% |