Application Checklist

Instructions:

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

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

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

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

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

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

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

☒ The following have been submitted on a CD:

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

For OHCA Use Only:

Docket No.: 16-32077-CON **Check No.:** 398550
OHCA Verified by: SD **Date:** 4/25/16

Needs to be filled out Pagination and fonts and spacing on the entire CON documents including supplemental forms needs to flow correctly. Also we did not check to be sure the Exhibit numbers in the narrative match the final table of contents

Saint Mary's
HOSPITAL

March 24, 2016

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 Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc.'s Acquisition of the Assets of Saint Mary's Health System Inc. and Franklin Medical Group, P.C.

Dear Ms. Martone,

Enclosed please find the original CON application for Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc.'s Acquisition of the Assets of Saint Mary's Health System Inc. and Franklin Medical Group, P.C., four copies and a CD.

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 believe that patients will benefit by having greater access to medical expertise and shared resources. We also expect operational efficiencies in the new affiliated system that will create a move secure financial base for the provision of health care in the local Waterbury community.

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.	Trinity Health – New England, Inc.,	Trinity Health Corp.
By: _____	By: _____	By: _____
Steven Schneider, MD President	Christopher M. Dadlez President and CEO	D. Scott Nordlund Executive V.P.

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A change in the ultimate controlling entity of Franklin Medical Group, P.C. from Saint Mary's Hospital, Inc. to Trinity Health - New England, Inc. fka Saint Francis Care Inc.
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State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

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

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** 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) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - 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) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - 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.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

Saint Mary's
HOSPITAL

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

N° 398550

51-7010/2111

DATE
03/22/2016

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 STREET
HARTFORD, CT 06106

TWO SIGNATURES REQUIRED IF OVER $50,000.00

⑈398550⑈ ⑆211170101⑆ 10 0010296451⑈

General Information

Name of Applicant:	Name of Co-Applicant:
Franklin Medical Group, P.C.	Saint Mary's Health System, Inc.; Trinity Health, Inc.; Trinity Health – New England, Inc.

Connecticut Statute Reference:

Conn. Gen. Stat. § 19a-638(a)(3)

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
	004230075	Physician Grp.	Franklin Medical Group, PC.
STREET & NUMBER			
56 Franklin Street			
TOWN		ZIP CODE	
Waterbury		06706	

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
STREET & NUMBER			
TOWN		ZIP CODE	

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 Chief Executive Officer of THNE-RHM	
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 ☒ NO ☐	See **Exhibit S3**
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☐ NO ☒	
Identify the Applicant's ownership type.	PC ☒ LLC ☐ Corporation ☐	Other: _____
Applicant's Fiscal Year (mm/dd)	Start 10/01/2015	End 09/30/2016

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, Saint Francis Hospital and Medical Center	
	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	

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: **Trinity Health**

Project Title: **Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.'s Acquisition of the Assets of Saint Mary's Health System Inc. and Franklin Medical Group, P.C.**

I, **D. Scott Nordlund, EVP, Growth, Strategy and Innovation of Trinity Health** being duly sworn, depose and state that the **Trinity Health** said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

3/21/16
Date

Subscribed and sworn to before me on 3/21/16

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. fka Saint Francis *Care* Inc.**

Project Title: **Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.'s Acquisition of the Assets of Saint Mary's Health System Inc. and Franklin Medical Group, P.C.**

I, Christopher Dadlez, Regional President and Chief Executive Officer of Trinity Health - New England, Inc. fka Saint Francis *Care* Inc. being duly sworn, depose and state that Trinity Health - New England, Inc. fka Saint Francis *Care* Inc. said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

3/23/16
Date

Subscribed and sworn to before me on March 23, 2016

Sheri Lemieux

Notary Public/~~Commissioner of Superior Court~~.

My commission expires: July 31, 2019

Affidavit

Applicant: **Saint Mary's Health System, Inc. and Franklin Medical Group, P.C.**

Project Title: **A change in the ultimate controlling entity of Franklin Medical Group, P.C. from Saint Mary's Hospital, Inc. to Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.**

I, Steven Schneider, MD, President of Franklin Medical Group, P.C. being duly sworn, depose and state that Franklin Medical Group, P.C., said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 3/24/16

Subscribed and sworn to before me on 3/24/16

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

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

Affidavit

Applicant: **Saint Mary's Health System, Inc. and Franklin Medical Group, P.C.**

Project Title: **A change in the ultimate controlling entity of Franklin Medical Group, P.C. from Saint Mary's Hospital, Inc. to Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.**

I, Chad W. Wable, FACHE, President and CEO of Saint Mary's Health System, Inc., being duly sworn, depose and state that Saint Mary's Health System, Inc., said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ 3/24/16
Date

Subscribed and sworn to before me on 3/24/16

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

VICTORIA CIPRIANO
NOTARY PUBLIC
MY COMMISSION EXPIRES FEB. 28, 2017

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 a new Trinity Health Regional Health Ministry (THNE-RHM) will become the sole corporate member of Saint Mary's Hospital, Inc. through a transfer agreement and the THNE-RHM will serve as the parent of Saint Mary's Hospital. It is anticipated that Saint Mary's Health System, Inc. will be dissolved, leaving Saint Mary's Hospital, Inc. (collectively referred to herein as "SMHS"). Franklin Medical Group, P.C. ("FMG") will remain as an affiliate of Saint Mary's Hospital. The key elements of this transaction include the following:

- Trinity Health, including the THNE-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 including FMG will join the THNE-RHM in a manner consistent with other organizations within the THNE-RHM. Please see **Exhibit 2** for the proposed THNE-RHM organization chart. SMHS will continue to meet the service needs of its population within its defined primary service area.
- FMG is a for profit affiliate of Saint Mary's Hospital. As a result of Saint Mary's Health System's organizational change, there will be a change in the governance structure/ultimate controlling entity of FMG from Saint Mary's Health System to THNE-RHM that is within the statutory definition of "transfer of ownership". Section 19a-630(16), C.G.S.
- Although no cash purchase price is contemplated, if the proposed transaction is approved, Trinity Health through the THNE-RHM will make substantial operational and financial commitments to SMHS and the communities it serves including:
  - Preservation and support of SMHS's 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 THNE-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 THNE-RHM Board of Directors will include two members from the SMHS community that will be appointed to the THNE-RHM.

- For three years following the effective date on which SMHS joins THNE-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's 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 SMHS and its related entities.
- FMG will remain a for-profit affiliate of Saint Mary's Hospital.

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 Franklin Medical Group, P.C., (an affiliate of Saint Mary's Health System, Inc.), Trinity Health – New England, Inc. formerly known as Saint Francis *Care*, Inc. and Trinity Health Corporation ("Trinity Health"). Trinity Health – New England, Inc. and Trinity Health operate as non-profit, 501(c)(3) corporations. The Franklin Medical Group, P.C. ("FMG") is a for-profit affiliate of Saint Mary's Hospital, part of an integrated Catholic healthcare delivery system serving the greater Waterbury, Connecticut community. Trinity Health – New England, Inc. is a regional provider of healthcare through Saint Francis Hospital and its numerous related facilities in the greater Hartford, Connecticut area, and joined Trinity Health on October 1, 2015 becoming Trinity's Regional Health Ministry serving New England Catholic health systems and hospitals (referred to herein as "THNE-RHM"). There is a certificate of need application ("CON") pending before OHCA (Docket No. 15-32045-CON) in which SMHS will become part of THNE-RHM. This application is submitted to enable FMG to join the THNE-RHM.

Franklin Medical Group, PC.

FMG is a multispecialty group with locations in the Greater Waterbury area. As of this writing, there are 90 providers employed by the medical group. FMG is an affiliate of Saint Mary's Hospital with a separate management structure and tax ID.

FMG providers have been providing high quality care to the communities in and around Waterbury. Many of the providers have been identified as top doctors by local publications.

Trinity Health – New England, Inc., (fka Saint Francis *Care*, Inc.) THNE-RHM

THNE-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. 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, Saint Francis *Care*, Inc. received approval from the Office of Health Care Access in Docket No. 15-31979-CON to join the Trinity Health. The transfer of Saint Francis *Care*, Inc. to Trinity Health and the formation of THNE-RHM became effective on October 1, 2015. If this application is approved, FMG, an affiliate of Saint Mary's Hospital will be joining THNE-RHM.

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 90 hospitals, and 124 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 $15.9 billion and assets of $23.4 billion, the organization returns about $1 billion to its communities annually in the form of charity care and other community benefit programs.

Trinity Health employs about 95,000 full-time employees, including 3,900 employed physicians. Committed to those who are poor and underserved in its communities, Trinity 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 health care economy, to a people-centered population health organization.

The Proposal

The proposal is an organizational change request to the governance structure/ultimate controlling entity of FMG as it becomes a part of THNE-RHM. This will be effectuated by a Transfer Agreement **(Exhibit 4** between Saint Mary's Health System, Inc., (which includes FMG), THNE-RHM and Trinity Health (collectively "the Parties"). THNE-RHM will become the sole corporate member of Saint Mary's Hospital and Saint Mary's Hospital will be a direct subsidiary of THNE-RHM. It is anticipated that Saint Mary's Health System will be dissolved, leaving Saint Mary's Hospital as the surviving entity. FMG will continue to operate as an affiliate of Saint Mary's Hospital. The proposed corporate structure is set forth in **Exhibit 2.**

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 FMG. Further, there is no capital cost associated with the Transfer Agreement between the Parties.

All assets and liabilities of Saint Mary's Health System, Inc. and FMG will remain assets and liabilities of SMHS and FMG respectively. Trinity Health and THNE-RHM have agreed to ensure the expenditure of One Hundred Million Dollars ($100,000,000) for capital needs 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 dollars ($10,000,000) of committed capital will be available to SMHS in the 4th year following the effective date. 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 dollars ($10,000,000) 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 THNE-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 THNE-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 THNE-RHM service area, including SMHS's Waterbury service area;

- enhance the quality of care provided in the THNE-RHM service area, as well as improve the overall patient experience including with respect to, without limitation, safety and satisfaction;

- reduce the costs of healthcare in the THNE-RHM service area, including SMHS's Waterbury service area;

- expand services in the THNE-RHM service area (which will include SMSH's Waterbury service area) through both strategic and organic growth, including the development and implantation of an ambulatory care strategy; and

- support physician alignment capabilities and initiatives that foster physician engagement, retain existing health care providers and recruit needed primary care and specialists to the SMHS's community 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 FMG, please see the answer to Question No. 8, below. Similarly, the THNE-RHM will not be adding or deleting services or any equipment as a result of this CON application and its geographic area will include SMHS's as a result of this CON application. For the specific details of the current service locations and geographic area served by THNE-RHM, please see OHCA Docket No. 15-31979.

Need for the Proposal in the Community

SMHS's motto, which extends to FMG, 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 5**).

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. FMG is affected by all of these changes and FMG sees its inclusion in a larger health care system as critical to its efforts to convert from the way healthcare has been delivered in the past to the way healthcare of the future must be delivered.

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 one 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.

SMHS was seeking a partner well before PPACA was passed into law. In developing the strategic plan each year, it became clear that with continual reductions in federal and state reimbursement for health care - combined with the expense for new information technology, pharmaceuticals and medical supplies and devices, SMHS needed to find a partner to help strengthen its ability to achieve overall cost efficiencies and further drive quality patient care.

The PPACA only heightened the need to partner with a strong healthcare entity. 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 updated to match current goals. The 2016-2020 Strategic Plan is attached as **Exhibit 6**. 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 5)**, 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. FMG is committed to its role as an integral partner in the delivery of value based care to patients in the Waterbury area.

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 PPACA 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's 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 THNE-RHM had a strategic plan very similar to its own, and Trinity Health has the experience to help both Connecticut systems achieve their goals. THNE-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 THNE-RHM service area. To achieve its vision of Best*Care* for a Lifetime, THNE-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, THNE-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 THNE-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 THNE-RHM from a provider of clinical services to a manager of the health of populations.

Christopher M. Dadlez, FACHE, the President and CEO of THNE-RHM, which will be the parent of SMHS, 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 THNE-RHM towards population management (see **Exhibit 14**a). 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.” THNE-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 THNE-RHM and Trinity Health are as follows:

- To have access to the resources of a large system at both the regional (THNE-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. fka Saint Francis *Care* Inc. ("THNE-RHM")

Saint Francis Care Inc. 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 Saint Francis Care Inc. sought to partner with Trinity Health are very similar to the reasoning of SMHS.

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

Saint Francis *Care* Inc. determined that Trinity Health was the ideal affiliation partner in that it satisfies the strategic, mission, financial and governance goals established by Saint Francis *Care* Inc. as part of its selection process. More particularly, Trinity Health enhances Saint Francis *Care* Inc. 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 Saint Francis *Care* Inc.;

- The transaction preserved and supported Saint Francis *Care* Inc.*'s* not-for-profit status, mission, values and Catholic identity;
- Access to Trinity Health system services provides operational efficiencies for THNE-RHM;
- Access to national best practices and expertise enhances THNE-RHM's, 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 THNE-RHM access to capital and provides an opportunity to lower THNE-RHM's cost of debt financing; and
- Trinity Health agreed to (i) develop a plan to enable THNE-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 Saint Francis *Care* Inc. to file a CON application with the Office of Health Care Access to become part of the Trinity Health system. (See OHCA approval of Docket Number 15-31979 CON on 8/31/15). THNE-RHM is continuing its pursuit of other like-minded health system partners to add to its regional ministry. As a part of this pursuit, Saint Francis *Care* Inc. 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 THNE-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 THNE-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 and FMG 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 THNE-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 THNE-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 THNE-RHM and Trinity Health physician leaders.

Throughout June 2015, H2C continued discussions with Connecticut Health Network (#2) and Trinity Health and THNE-RHM (#1). By early July Trinity Health, THNE-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 THNE-RHM, and commenced a 30-day exclusivity period with Trinity Health and THNE-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 THNE-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, THNE-RHM. On September 18, 2015 the three parties signed the Transfer Agreement.

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

FMG was apprised of the process between Saint Mary's Hospital, THNE-RHM and Trinity Health prior to the Saint Mary's Hospital's Board vote. After discussions with Saint Mary's Hospital, FMG met and resolved that it wanted to remain affiliated with Saint Mary's Hospital as it became part of THNE-RHM. The resolution affirming this decision is attached as **Exhibit 1**.

Since September 18th, 2015 the parties have been focused on completing necessary regulatory filings, including those required by OHCA.

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 services are included in this Certificate of Need Application.

D. Scott Nordlund, EVP, Growth, Strategy and Innovation

Please refer to **Exhibit 11** 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 12** 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 4** 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 parties involved in this CON application as well as their affiliated health care providers are in compliance with existing laws. This application will not change any of the existing health services now offered by SMHS, including FMG.

§ *"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.**

   The Transfer Agreement between SMHS, Saint Francis *Care,* Inc. now known as Trinity Health – New England, Inc. 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, including FMG, 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 regional and national health care system 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 is a key driver in today's health care environment. Connecticut hospitals are pursing affiliation arrangements and mergers as a means of offsetting financial pressures due to the provision of uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients and reduced reimbursement by the government payers and health insurers. Hospitals are struggling to make needed facility improvements and acquire needed technology. (Plan at pp. 7-8, Sec. 1.8.5 and pp. 11-12, Sec. 2.1.1). This proposal serves as an example of this trend. The implementation of the proposal will allow SMHS to meet its financial obligations, make needed capital improvements, acquire new technology and continue to be a safety net provider in the Greater Waterbury region.

As part of the THNE-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). THNE-RHM will provide the necessary allocation of capital to invest in a HITE and electronic health records ("EHRs"). Paper records used in some of the FMG locations will be replaced by EHRs to report patients' diagnostic data. This will be of enormous assistance to the physicians in FMG. By allowing them to efficiently share data, FMG will greatly benefit from Trinity Health's Physician Network Operations programs and services. FMG will have the ability to benchmark their clinical and financial performance with not only the THNE-RHM, but also with the entire Trinity Health system allowing it to improve its operations and enhance the care it provides. FMG will also be able to benchmark with the total Trinity Health physician network their patient satisfaction through the use of the Press Ganey tool. When opportunities to improve the patient experience of care arise, FMG will able to utilize the workshops and/or customized improvement plans that Trinity Health offers. Trinity Health has embarked on a care re-design process aimed at improving population health. This will be shared with FMG through a system-led collaborative process involving caregivers and administrators focusing on improving outcomes through redesign. Trinity Health has established well designed toolkits to assist in the recruitment and acquisition of physicians that serves to mitigate legal and financial risk. Trinity Health also has developed budgeting and financial reporting tools that along with the aforementioned toolkits, will be made available to FMG. Affiliating with Trinity Health allows FMG to avoid the expense of hiring consultative services to accomplish the tasks mentioned thereby reducing costs. THNE-RHM will assist SMHS's physicians through participation in health delivery protocol and system changes identified by its Connecticut Institute for Primary Care Innovation and the introduction of new technology and practice approaches that have been tested in the Innovation + Learning Center.

Opportunities to regionalize the health care delivery system in the greater Waterbury area will be enhanced, building upon existing initiatives. The size of the Trinity Health will provide SMHS with regional and national economies of scale 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. The collaboration with Trinity Health and its experience will provide an environment that SMHS's physicians and other SMHS's 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.

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

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

a. identify the target patient population to be served;

SMHS (which includes FMG) 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.

Figure 1: SMHS Service Area

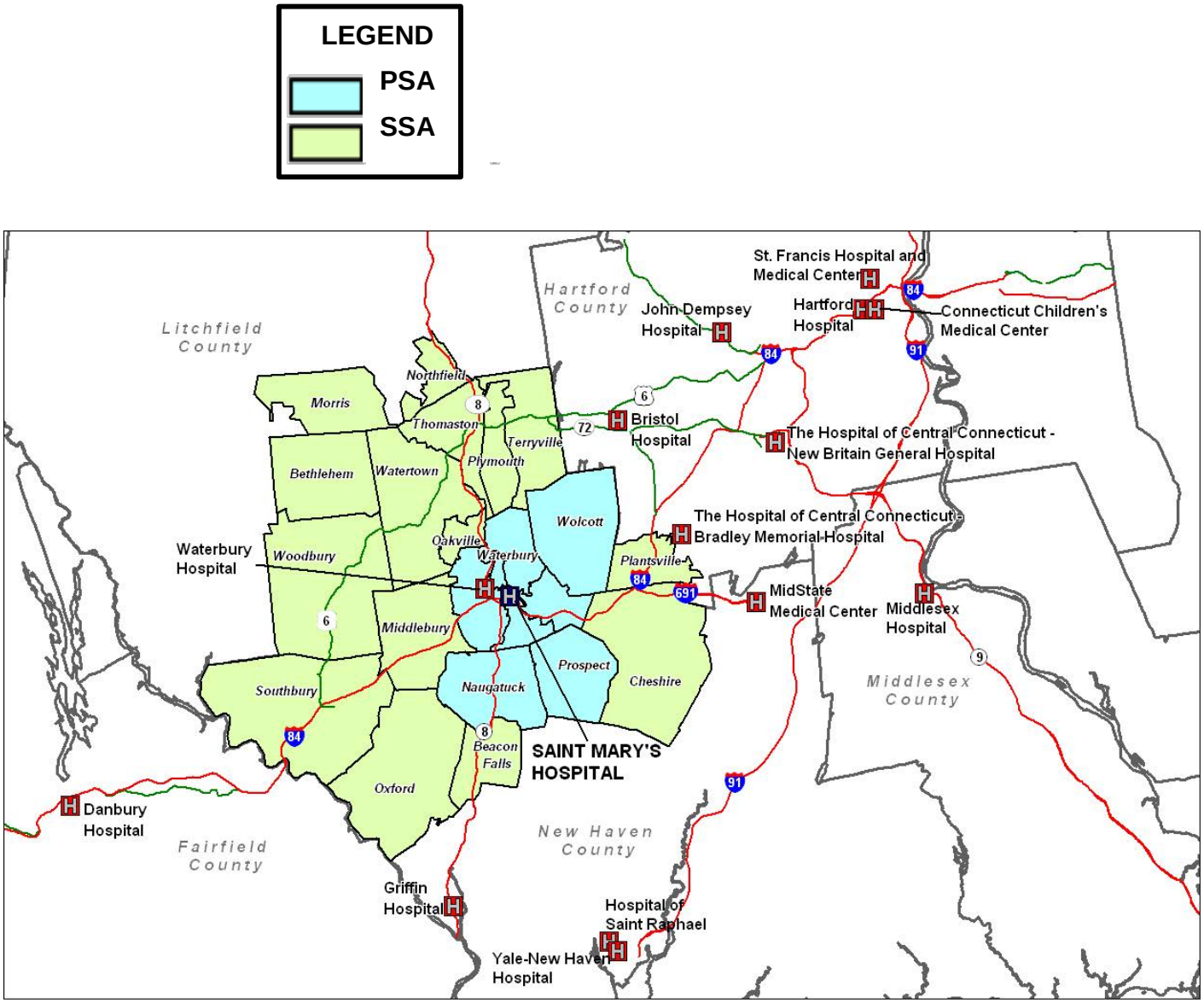
LEGEND
PSA
SSA
Litchfield County
Hartford County
Middlesex County
New Haven County
Fairfield County
St. Francis Hospital and Medical Center
John Dempsey Hospital
Hartford Hospital
Connecticut Children's Medical Center
Bristol Hospital
The Hospital of Central Connecticut - New Britain General Hospital
The Hospital of Central Connecticut - Bradley Memorial Hospital
MidState Medical Center
Middlesex Hospital
Waterbury Hospital
SAINT MARY'S HOSPITAL
Danbury Hospital
Griffin Hospital
Hospital of Saint Raphael
Yale-New Haven Hospital
Northfield
Morris
Thomaston
Terryville
Plymouth
Bethlehem
Watertown
Wolcott
Oakville
Waterbury
Woodbury
Plantsville
Middlebury
Prospect
Cheshire
Southbury
Naugatuck
Beacon Falls
Oxford

Table 1 provides a summary of the population of the service area from 2000 projected to 2020. The City of Waterbury in SHMS's PSA 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 by FMG's Waterbury practices. 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. FMG supports the addition of providers who are enrolled in the NHSC Loan Repayment Program through establishing medical practices in HSPAs. This proposal provides the necessary financial resources and cost savings opportunities to ensure that health care services will remain available to the vulnerable population in the Greater Waterbury area.

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 FMG 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;

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

- Medical Cardiology
- General surgery
- Medical Oncology
- Pediatrics
- Primary Care
- Breast Surgery
- Colorectal Surgery
- Gastroenterology
- Pulmonary
- Endocrinology
- Critical Care Medicine
- Rheumatology
- Psychiatry
- Internal Medicine

FMG, a physician group of approximately 90 physicians and 46 midlevel providers have 19 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) 1177 New Haven Road, 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, Waterbury; Specialty: Gastroenterology; Internal Medicine
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;
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
18) 1389 W Main St Ste 224, Waterbury, CT 06708: Internal Medicine
19) 385 Main St S # 106, Southbury, CT 06488: Internal Medicine

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. FMG is made up of practices that have either joined the group and SMHS has assumed the leases of their locations or has placed physicians based on community need.

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's Catholic mission which also applies to FMG 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.

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 FMG are planned at this time as a direct result of this proposal. THNE-RHM will provide additional support for continuing quality improvement of the clinical services provided at FMG, and at this time no changes in clinical services are being proposed. Going forward, if this proposal is approved, as proposed changes are identified, THNE-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 FMG 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 response to question 2 above.

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

9. Describe how the proposal will:

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

FMG will have access to THNE-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 THNE-RHM.

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 affiliated with the Yale School of Medicine 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. Many of SMHS's physicians have faculty roles at Yale. 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 THNE-RHM. The following are examples of the educational and health care innovations efforts of THNE-

RHM that present opportunities for SMHS's physicians and staff:

- THNE-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. THNE-RHM focus on population management and health outcomes is also regularly stressed as part of its various teaching endeavors.

- THNE-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 THNE-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 THNE-RHM system. 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.

- THNE-RHM maintains independent, hospital-based fellowships and residency programs and also participates in the University of Connecticut School of Medicine Integrated Residency Training Programs. THNE-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. THNE-RHM is also a member of the Council on Teaching Hospitals and the Association of American Medical

Colleges. A list of residencies offered at THNE-RHM through the University of Connecticut School of Medicine is included in **Exhibit 15.**

- THNE-RHM offers programs for various allied health professions and disciplines to rotate through various departments of Trinity Health-New England, Inc. These allied health professionals include medical technologists, radiological technologists, physical therapists, respiratory therapists and technicians, physician assistants, pharmacists and nurse practitioners.

In addition, THNE-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.

THNE-RHM believes that what can be measured can be improved. Accordingly, THNE-RHM's service lines integrate a variety of clinical data bases as registries for standardized bench marking and quality performance assessment. THNE-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 16.**

By joining THNE-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 THNE-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. 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 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. The clinicians in the UCO will work collaboratively with physicians at SMHS and THNE-RHM to develop methods to deliver evidenced based medicine that promotes the highest quality, safest and most effective care for every patient, every time. SMHS, through the UCO, will have access to this infrastructure and will participate in these patient care 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 11.1% between FY 2010 and December 2014 and saved a total of 2,912 lives.
- 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 0.4% in September 2015.
- Sponge accounting Safety Audit Compliance rate was 97% in 2015 for the first cohort. The second cohort obtained a 98.2%. Sponge Accounting Safety Audit Compliance rat post implementation. - Safety Checklist Perfect Patient Score improved from 48% in January 2013 to exceeding a system target of 77%.Combined Trinity Health Overall Perception of Safety score improved 3.9% from 59% in 2014 to 62.9% in 2015.
- Trinity Health Physician Network created at customized TeamSTEPPS curriculum for Ambulatory Care that is grant funded and actively being deployed over a 2- year period. The program has been implemented in 8 sites, including primary care offices.

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.

FMG will participate in all these programs, taking away best practices and additional learning to supplement its favorable quality and patient satisfaction scores. The providers at FMG will have the ability to utilize these best practices both in their outpatient practice, but also while at SMHS. They can rely on THNE-RHM in assisting them in successfully adopting these quality improvement initiatives. In short, THNE-RHM's approach to clinical quality will complement and build upon FMG's strong clinical quality. This combined approach to clinical quality will significantly benefit FMG's patients.

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. THNE-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.

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

This proposal will preserve local access to healthcare for the patients in the FMG service area, including the indigent and Medicaid recipients by providing a greater level of long term financial stability for FMG. The integration of FMG into THNE-RHM is anticipated to enhance access and quality of health care. As an integral part of THNE-RHM and its physician enterprises, FMG physicians will have improved access to the specialists that it may not have in its group, or ready access to them in the greater Waterbury area. Some examples of these specialties are Gynecologic Oncology where SMHS's patients have to seek care outside of the area if they are in need of advanced GynOnc care. Another benefit will be the ability to quickly share information with the THNE-RHM providers through the EPIC EHR. Having ready and immediate access to the patient's complete record will undoubtedly improve the coordination of care.

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 FMG into the THNE-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 FMG into THNE-RHM, cost savings can be realized through group purchasing savings of bulk supplies as multiple vendor contracts will be consolidated. Recruitment costs to bring on new providers may decline as recruitment efforts could be managed at the THNE-RHM level therefore reducing the administrative costs of these searches. Recruitment can be made in a shared offering between FMG and its partner organizations within THNE-RHM where the demand for such a provider is such that they would not be economically sustainable due to adequate demand. These providers can practice in multiple locations within the THNE-RHM. Additional improvements to the cost effectiveness in the region will come from standardization of protocols, sharing of electronic health information, shared administrative functions and the potential sharing of staff amongst sites.

THNE-RHM and SMHS are committed to preserving a viable health care organization dedicated to providing health care services that meet the needs of the SMHS'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)?

FMG's joining THNE-RHM delivers many benefits which will improve the coordination of patient care including:

- Through 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 of care offered by THNE-RHM and its partners;
- The health ministry's commitment to people centered care and population health;
- Provides 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;
- Access to Trinity Health's Physician Network Operations programs and services.

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

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

> *§ "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))*

Please see the charity care policy attached as **Exhibit 18.** FMG has adopted SMHS's charity care policy.

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

> *§ "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's irrespective of this proposal. Please see response to Question 11 above.

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

There are no planned changes in price structure or clinical services as a result of this organizational change.

Financial Information

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

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

In an era of healthcare reform and diminishing resources, the transfer of SMHS's membership to THNE-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".

THNE-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 THNE-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 THNE-RHM also believes in healthcare innovation as a way to promote both quality and cost containment. The THNE-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 Hospital is relevant to this application because it demonstrates the value and cost savings that result from consolidation. As SMHS becomes part of the THNE-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, Inc. ("SFHCP") on January 27, 2009.

Today, Saint Francis Health*Care* Partners 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 EHR. The alignment within the THNE-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 THNE-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.

<u>Foundation of our Contracting Model:</u>

The commitment at THNE-RHM to its patients is “best *care* for a lifetime”. All components to SMHS’s overall mission and focus begin there. Even SMHS’s 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 THNE-RHM 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:

Commercial
Aetna
Anthem

CIGNA
ConnectiCare
United/Oxford

Medicare Advantage:
Aetna
Anthem
ConnectiCare
United/Oxford- as of April 1, 2016
WellCare

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[1]. 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, THNE-RHM embarked upon the

1 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.

development of a post-acute care affiliated network that closely links the hospital to the continuum of post- acute providers including 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 THNE-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 THNE-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 THNE-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 THNE-RHM.

Once SMHS joins the THNE-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 THNE-RHM's electronic medical record and use the INTERACT tool kit to manage patient flow between the post – acute providers and SMHS.

2. <u>Materials Management</u>

The THNE-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 THNE-RHM. In addition, both THNE-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 THNE-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 18**. For a more detailed explanation of the community benefit of both organizations, please refer to **Exhibit 19** which contains the 2014 Community Benefit Reports for Saint Francis *Care* (now known as THNE-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.

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

Please refer to table 3 below**.**

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

This question is not applicable.

18. Include as an attachment:

a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial

documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

Please refer to **Exhibit 20.** SMHS's consolidated audited financials include FMG since it is an affiliate under the hospital.

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

Please refer to **Exhibit 17**.

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

Please refer to Table 4 below.

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

The following financial information represents SMHS's consolidated actual or projected results for the years identified. FY 2015 actual results are preliminary unaudited results. FY 2016 amounts represent the budget approved by the Board of Directors for SMHS.

- 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 SFY 2016. If the State further reduces funding, actual results may differ. This amount is included in "Other Operating Revenue", Line 15.
- The FY 2016 approved budget includes the original State approved supplemental payment projections for SFY 2016, for which the Hospital was allocated $11.7 million. The governor has indicated his intent to cut all the supplemental funding related to our fiscal year. Management is working on a revised budget given the projected reduction in funding. This amount is included in "Other Operating Revenue", Line 15.

- The existing CHEFA debt was refinanced in 2015, resulting in a reduction in Interest Expense, Line 10.

The following summarizes key assumptions used in projecting the FY 2017, 2018 and 2019 operating results:

- 2017 is the first full year of implementation of the proposal.
- 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.
- Bad debts as a percentage of gross revenues are expected to remain flat.
- In order to achieve SMHS's strategic plan of improving population health, enhancing the patient care experience and controlling costs, the projected amounts include an expectation that SMHS will begin to assume risk contracts in FY 2017.
- 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.
- Incremental reductions in expenses are expected with implementation of the proposal due to purchasing arrangements with Trinity Health. These reductions are reflected in Line 4, "Supplies and Drugs" and Line 10, "Other Operating Expenses".

There are no planned changes to the clinical services offered by SMHS or its subsidiaries 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 the THNE-RHM intended to best meet community health care needs.

The assumptions for FMG are that this proposal will result in no projected changes for the immediate future.

If any proposed investment requires additional regulatory approval, this approval will be obtained prior to the investment being made.

21. 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.

22. 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))*

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

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

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

Patient volume is expected to grow at a 5% rate as new providers continue to fill their patient panels. FMG has recently experienced a growth in primary care due to an increase in employed community based providers joining the group. Demand for cardiology has led to the addition of 2 new cardiologists within the past year with an additional one coming on board this year.

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

> *§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;"*

(Conn.Gen.Stat. § 19a-639(a)(7))

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

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

    Please refer to response to question 8A.

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

    § "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.* .**

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

    Please see **Exhibit 21.**

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

    This proposal has no effect on existing providers therefore there is no expected change in any services at SMHS or FMG.

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

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

31. 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))*

32. 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 including FMG's health services will remain as is if this proposal is approved.

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

THNE-RHM believes that FMG 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 FMG joining THNE-RHM, the residents in FMG's 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
Breast & Oncology	33 Bullet Hill Rd. Southbury		M - F, 8:30 - 4:30	
Cardiology	1320 West Main St. Waterbury		M - F, 8:30 - 4:30	
Cardiology	56 Franklin St., Waterbury		M - F, 8:30 - 4:30	
Pulmonary	133 Scovill St. Ste.104 Waterbury		M - F, 8:30 - 4:30	
Gastroenterology	140 Grandview Ave. Waterbury		M - TH, 8:30 - 4:30, Closed Friday	
Sleep Medicine	1320 West Main St. Waterbury		M - TH, 8:45 - 5, Fri. 8 - 12	
Primary Care	70 Heminway Park Rd. Watertown		M - F, 8 - 5	
Infectious Disease	133 Scovill St. Ste.102, Waterbury		M - F, 8-4:30	
Primary Care	503 Wolcott Rd. Wolcott		M - F, 8-4	
Primary Care	503 Wolcott Rd. 2nd Floor Wolcott		M - F, 9-5	
Primary Care	117 New Haven Rd. Naugatuck		M, W, Th, F 7 - 4:30; Tues 7 - 6:30	
Primary Care	133 Scovill St. Ste.102, Waterbury		M - F, 8-4:30	
Primary Care	1981 East Main St. Waterbury		M - TH 8:30 - 5, Fri 8:30 - 2	
Primary Care	95 Scovill Street Pavillion B, Waterbury		M - F, 8 - 5:30	
Pediatrics	95 Scovill Street Pavilion B, Waterbury		M - F, 8 - 5:30	
Pediatrics	166 Waterbury Rd. Prospect		M,T, Fri, 8 - 5, W & TH 8 - 7:30	
Primary Care	166 Waterbury Rd. #300 Prospect		M - F, 8-5	

Breast & Oncology	166 Waterbury Rd. #300 Prospect		M - F, 8:30 - 5	
GYN	167 Waterbury Rd. #300 Prospect		M - F, 7:30 - 3	
Ortho PA	133 Scovill St. Ste.308 Waterbury		W 8:30 - 4:30	
Surgery	133 Scovill St. Ste.303 & 308 Waterbury		M - F, 8:30 - 4:30	
Surgery	590 Middlebury Rd. #A Middlebury		M - F, 8:30 - 4:30	
Gastroenterology	60 Westwood Ave #314 Waterbury		M - F, 8:30 - 4:30	
Oncology/Hematology	1075 Chase Parkway Ste A Waterbury		M - F, 9 - 5	
Primary Care	714 Chase Parkway Suite 6 Waterbury		M, W, Th, F 8:30 - 5; Tues 8:30 - 5:15	
Breast & Oncology	900 Main Street South Bldg. 2 Ste 101 Southbury		M - F, 8:30 - 4:30	
Primary Care	60 Westwood Ave #250 Waterbury		M & W, 8:30 - 4:30, Th & Fri 8:30 -3:30, Closed Tuesday	
Primary Care	385 Main Street South, Ste 106, Southbury		M - F, 9 - 5	
Rheumatology/Primary Care	133 Scovill St. Suite 306, Waterbury		M - F, 8- 5	
Dental	133 Scovill St. Suite 209, Waterbury		M - F, 8:30 - 4:30	
Primary Care	1389 West Main St. Ste. 224, Waterbury		M 8 - 4:30, T 8 - 4:30, W 8:30- 4:30, TH 8 - 4, F 8:30-12:30 (2nd + 4th) Closed 1st + 3rd	

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TABLE 2
SERVICE AREA TOWNS

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

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%

* Village or place names are not acceptable.

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TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

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

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TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2016*	**FY 2017***	**FY 2018***
Revenue from Operations	$37,476	$38,716	$39,907
Total Operating Expenses	$54,672	$55,965	$57,367
Gain/Loss from Operations	**(17,196)**	**(17,249)**	**(17,460)**

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

[back to question]

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2013***	FY 2014***	FY 2015***	FY 2016 (1 Month)***
Primary Care	52,389	46,997	105,681	13,386
Cardiology	17,812	18,985	26,736	1,759
Breast Surgeons	5,183	5,853	13,268	1,611
Surgery	5,416	9,481	12,199	1,265
Gastroenterology	3,121	5,327	15,678	1,279
Oncology/Hematology		2,496	3,328	191
Rheumatology			614	298
GYN	2,706	2,754	2,219	1
Sleep	3,128	3,569	3,789	324
Pulmonary & Critical Care	7,960	8,108	10,493	545
Infectious Disease	5,275	5,541	5,596	234
Pediatrics		4,300	12,907	1,127
Behavioral Health (IP & OP)	16,404	17,819	20,490	1,646
Academic	33,988	37,398	50,462	2,101
Hospital Based	49,321	43,216	47,346	4,835
Total	**202,703**	**211,844**	**330,806**	**30,602**

* 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.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE

	Projected Volume		
Service*	**FY2016****	**FY2017****	**FY2018****
Primary Care	110,965	116,513	122,339
Cardiology	28,073	29,476	30,950
Breast Surgeons	13,931	14,628	15,359
Surgery	12,809	13,449	14,122
Gastroenterology	16,462	17,285	18,149
Oncology/Hematology	3,494	3,669	3,853
Rheumatology	645	677	711
GYN	2,330	2,446	2,569
Sleep	3,978	4,177	4,386
Pulmonary & Critical Care	11,018	11,569	12,147
Infectious Disease	5,876	6,170	6,478
Pediatrics	13,552	14,230	14,941
Behavioral Health (IP & OP)	21,515	22,590	23,720
Academic	52,985	55,634	58,416
Hospital Based	49,713	52,199	54,809
Total	347,346	364,714	382,949

* 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.

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2015**		FY 2016**		FY 2017**		FY 2018**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	Discharges
Medicare*	5,289	45%	5,313	45%	5,276	45%	5,240	5,289
Medicaid*	3,703	31%	3,696	31%	3,683	31%	3,671	3,703
CHAMPUS & TriCare	22	0%	22	0%	22	0%	22	22
Total Government	9,014	76%	9,031	76%	8,981	76%	8,933	9,014
Commercial Insurers	2,601	22%	2,613	22%	2,604	22%	2,594	2,601
Uninsured	103	1%	102	1%	102	1%	101	103
Workers Compensation	129	1%	129	1%	129	1%	129	129
Total Non-Government	2,833	24%	2,844	24%	2,835	24%	2,824	2,833
Total Payer Mix	11,847	100%	11,875	100%	11,816	100%	11,757	11,847

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

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TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2015**
WATERBURY	57.2%
NAUGATUCK	9.7%
WATERTOWN	7.9%
WOLCOTT	7.9%
PROSPECT	4.3%
SOUTHBURY	2.2%
MIDDLEBURY	2.2%
CHESHIRE	1.9%
THOMASTON	1.6%
WOODBURY	1.4%
PLYMOUTH	1.0%
BETHLEHEM	0.7%
SOUTHINGTON	0.6%
OXFORD	0.6%
BEACON FALLS	0.6%
MORRIS	0.2%
Subtotal Total Service Area	**91.2%**
Other Towns	8.8%
Total	**100.0%**

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

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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

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

Please see **Exhibit 21.**

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Supplemental CON Application Form

Transfer of Ownership of a Group Practice

Conn. Gen. Stat. § 19a-638(a)(3)

Applicants: Franklin Medical Group, P.C., an affiliate of Saint Mary's Hospital, Inc.; Trinity Health - New England, Inc. fka Saint Francis *Care* Inc. and Trinity Health, Inc.

Project Name: A change in the ultimate controlling entity of Franklin Medical Group, P.C. from Saint Mary's Hospital, Inc. to Trinity Health - New England, Inc. fka Saint Francis Care Inc.

Affidavit

Applicant: **Trinity Health-New England, Inc. fka Saint Francis *Care* Inc.,**

Project Title: **Trinity Health - New England, Inc. fka Saint Francis *Care*, Inc.'s Acquisition of the Assets of Saint Mary's Health System Inc. and Franklin Medical Group, P.C.**

I, **Christopher Dadlez, Regional President and Chief Executive Officer of Trinity Health - New England, Inc. being duly sworn, depose and state that Trinity Health - New England, Inc. fka Saint Francis *Care*, Inc.** said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 3/23/16

Subscribed and sworn to before me on March 23, 2016

Sheri Lemieux

Notary Public/~~Commissioner of Superior Court~~

My commission expires: July 31, 2019

Affidavit

Applicant: **Trinity Health**

Project Title: **Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.'s Acquisition of the Assets of Saint Mary's Health System Inc. and Franklin Medical Group, P.C.**

I, **D. Scott Nordlund, EVP, Growth, Strategy and Innovation of Trinity Health** being duly sworn, depose and state that the **Trinity Health** said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

3/21/16
Date

Subscribed and sworn to before me on 3-21-16

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: **Saint Mary's Health System, Inc. and Franklin Medical Group, P.C.**

Project Title: **A change in the ultimate controlling entity of Franklin Medical Group, P.C. from Saint Mary's Hospital, Inc. to Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.**

I, Steven Schneider, MD, President of Franklin Medical Group, P.C. being duly sworn, depose and state that Franklin Medical Group, P.C., said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 3/24/16

Subscribed and sworn to before me on 3/24/16

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

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

Affidavit

Applicant: **Saint Mary's Health System, Inc. and Franklin Medical Group, P.C.**

Project Title: **A change in the ultimate controlling entity of Franklin Medical Group, P.C. from Saint Mary's Hospital, Inc. to Trinity Health - New England, Inc. fka Saint Francis *Care* Inc.**

I, Chad W. Wable, FACHE, President and CEO of Saint Mary's Health System, Inc., being duly sworn, depose and state that Saint Mary's Health System, Inc., said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ 3/24/16 Date

Subscribed and sworn to before me on 3/24/16

Victoria Cipriano

Notary Public/~~Commissioner of Superior Court~~

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

1. **Project Description: Transfer of Ownership of a Group Practice**

   a. **Is the proposed transfer the result of a request for proposal or other similar voluntary offer for sale? Please explain in detail and provide dates and documentation.**

   Franklin Medical Group, P.C. ("FMG") is a for-profit affiliate of Saint Mary's Hospital, a subsidiary of Saint Mary's Health System, Inc. (collectively referred to herein as "SMHS"). The 90 member physician practice has worked collaboratively with SMHS for years, providing outstanding care for the patients in Waterbury and the surrounding towns in its service area. FMG has known for a number of years that SMHS was interested in affiliating with a larger health care provider in order to continue offering quality health care; a provider who would not only be a leader in the field for the sake of Saint Mary's Hospital and its other affiliates, but also for FMG. The brightest physicians are attracted to a practice and a hospital where there is excellence, innovation, academic interaction and best practices in medicine.

   The proposed transfer of ownership of FMG to Trinity Health - New England, Inc. fka Saint Francis *Care* Inc. ("THNE-RHM") is the result of the request for proposal issued in February of 2015, by SMHS's advisor Hammond Hanlon Camp, LLC ("H2C") to non-profit health care entities that either had, or would soon have, a presence in Connecticut. At that time, THNE-RHM was already planning to join Trinity Health, creating a base in Connecticut for Trinity Health to provide an anchor for its New England health care providers. Trinity Health was one of the entities contacted by H2C. The interaction between Trinity Health and SMHS began in early March of 2015. On March 24, 2015, THNE-RHM met with SMHS's Board-appointed Affiliation Taskforce. In late May 2015, several SMHS's taskforce members conducted a site visit to Mercy Medical Center in Springfield, Massachusetts, a Trinity Health facility.

   In June of 2015, H2C continued discussions with Trinity Health and one other potential partner to clarify specific issues. In mid-July 2015, an intensive due diligence process began. SMHS opened up the full data room to Trinity Health and THNE-RHM and commenced a 30-day exclusivity period with Trinity Health and THNE-RHM. H2C presented the Saint Mary's Board with a high level comparison of offers. A taskforce issues list was created for Trinity Health and THNE-RHM and one other

potential partner, (Health Network #2 where the two entities were compared on the following topics: strategic, pension, financial, canonical/ethical religious directives, 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.

Based on the recommendation of the SMHS's Board taskforce, the full board voted on September 13, 2015 to approve entering into a transfer agreement with Trinity Health and THNE-RHM for SMHS to become part of THNE- RHM. On September 18, 2015 the three parties signed the transfer agreement.

Throughout the process, FMG has been apprised of discussions. Dr. Schneider, President and CEO of FMG participated in meetings with THNE-RHM and Trinity Health.

b. Explain how each Applicant determined the public's need for the proposal to occur and discuss the benefits of this proposal for the public (discuss each separately).

From the perspective of FMG and SMHS, the public need for this application derives mainly from the 2010 Patient Protection and Affordable Care Act ("PPACA") and the Waterbury Community Needs Assessment. New models for reimbursement and new models for providing health care are required in order to be able to offer health care to a larger segment of our population at the same time that costs are rising. There is also a new emphasis on wellness. Physicians need to treat the sick and injured, but also keep the population healthy. Focusing on wellness not only creates a stronger, healthier population, but it also reduces health care costs. However, for physicians, this means adjusting from primarily treating illness to becoming focused on preventing illness. Prevention is to become the cornerstone of well-developed healthcare delivery systems. The goal is to avoid expensive treatments for conditions that ought to have been prevented and/or managed better. Examples of some of these conditions are diabetes, hypertension and behavioral health. FMG can benefit from the economies of scale and experiences of a national organization like Trinity Health whose recent focus has been population health.

All of the needed restructuring to accomplish population health goals that are going to be done may require capital investments for additional office locations, but also of great importance is the experience that an individual healthcare provider can tap into for the benefit of future healthcare delivery. The public is aware of the increased cost associated with quality improvement initiatives, developing physician partnerships, creating clinical service redesign, developing electronic medical records, repairing the aging infrastructure of SMHS and the need to provide the health services referenced in the Waterbury Community Needs Assessment. (**Exhibit 5)** At the same time these external pressures have emerged, the age of the population in Waterbury is rising, and the median age of the population is older than the rest of the State (44 vs. 40). In general, an older population utilizes more health services, than a younger population. See response to ***Question 8(a), Table 1*** in the Main Application. FMG and SMHS evaluated the systems and process that THNE-RHM and Trinity Health, have already implemented as they established THNE-RHM. Both FMG and SMHS know that they will benefit from the experiences of THNE-RHM and Trinity Health, and SMHS's community will be the ultimate benefactor.

Trinity Health and THNE-RHM see a need to build a larger health network in Connecticut with health care providers who share the same goals and values. Even the strategic planning for SMHS and FMG are similar to those of Trinity Health and THNE-RHM as both focus on managing populations through clinically integrated networks and ambulatory care development. With a larger network of healthcare providers who have the same vision, and are willing to work hard to make health care better for the public they serve, Trinity Health and THNE-RHM are certain that the benefits to the community serves more than justifies the efforts to be undertaken.

c. Describe the transition plan and how the Applicants will ensure continuity of services to the patient population. Provide a copy of any 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 practices. If clinical services are added or

eliminated in the future, the Applicants will seek a Certificate of Need as required.

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

i. **Legal chart of corporate structure including all subsidiaries and affiliates**.

The corporate organization charts are attached in **Exhibit S1**. The proposed organization charts provided include the THNE-RHM and SMHS. (See **Exhibit 4**).

ii. List of owners and the % ownership and shares of each.

Dr. Michael Simms and Dr. James Uberti each own 50% of FMG which is 100 shares per owner.

e. Does this proposal avoid the corporate practice of medicine? Explain in detail.

This proposal does not impact the corporate practice of medicine. FMG's shareholders, Dr. Simms and Dr. Uberti are licensed physicians, and each of the other physicians who are part of FMG are also duly licensed. Professional fees are paid by their patients and third party payors (largely through Medicare, Medicaid, commercial insurance companies and charity care) for the medical treatment performed. There is no change planned, corporate or otherwise as a result of this proposal.

f. Has the Applicant notified the Attorney General's office in writing of the proposed "material change," as defined Conn. Gen Stat. § 19a-486i(c)?

Notification to the AG's office was mailed on March 24, 2016. (**See Exhibit S2.**)

2. Financial Information

a. **Describe how this proposal is cost effective and provide an itemization of anticipated cost savings that will result from this proposal.**

This proposal is cost effective as SMHS, including FMG, will derive financial benefit from the proposed transaction by joining the THNE-RHM. These benefits include a lower cost of capital, reduced operating expenses resulting from SMHS's inclusion in Trinity Health's corporate services and program initiatives such as group purchasing and develop a plan to fully fund SMHS's pension liability SMHS will be able to manage its cost structure by sharing and/or centralizing certain expenses such as the cost of health information technology development and implementation. All of these opportunities will result in SMHS's and FMG's ability to provide high quality care at the lowest possible cost.

As an affiliate of Saint Mary's, FMG is a part of the transaction that is more fully described in the Certificate of Need Application (Docket Number: 15-32045-CON), submitted on November 15, 2015. The cost effectiveness of the project and the financial benefits to SMH's overall and FMG specifically have also been submitted in that application.

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.**

The proposal is not being submitted due to provisions of the Federal Sherman Antitrust Act or Conn. Gen. Stat. 35-24 et. seq.

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

SMHS was seeking a partner well before PPACA was passed into law. In developing the strategic plan each year, it became clear that with continual reductions in federal and state reimbursement for health care - combined with the expense for new information technology, pharmaceuticals and medical supplies and devices, SMHS needed to

find a partner to help strengthen its ability to achieve overall cost efficiencies and further drive quality patient care.

The PPACA heightened the need to partner with a strong healthcare entity. 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 Saint Mary's in the healthcare system of the future, a system fundamentally different from the fee for service approach to healthcare delivery. The plan is continuously updated to match current goals. The 2016-2020 Strategic Plan is attached as Exhibit 6. 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 5**), 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. FMG is committed to its role as an integral partner in the delivery of value based care to patients in the Waterbury area.

The need to upgrade FMG medical records to the standard required as a result of the PPACA and reduce costs is another driving force. As part of a larger region, SMHS and FMG will have access to a sophisticated cutting edge electronic medical record system that will enable FMG physicians to spend more time with patients and benefit from a fully integrated record.

EXHIBIT 1

FRANKLIN MEDICAL GROUP, P.C.

UNANIMOUS WRITTEN CONSENT
IN LIEU OF SPECIAL MEETING OF THE DIRECTORS AND SHAREHOLDERS

February 19, 2016

The undersigned, being all the directors (the "Directors") and the shareholders (the "Shareholders") of Franklin Medical Group, P.C., a Connecticut professional services corporation, (the "Company"), do hereby consent to and adopt the following resolutions with the same force and effect as if duly adopted at a special meeting of the Directors and Shareholders called for said purpose:

WHEREAS, the Directors and Shareholders have reviewed and considered that certain Transfer Agreement dated September 18, 2015, by and among Saint Francis Care, Inc., Trinity Health Corporation ("Trinity Health"), Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. ("SMH") (the "Transfer Agreement"), pursuant to which Trinity Health New England, Inc. ("THNE"), a subsidiary of Trinity Health, will become the sole corporate member of SMH and serve as SMH's parent (the "Transaction").

NOW THEREFORE, be it:

RESOLVED, that the Directors and Shareholders, on behalf of the Company, deem it advisable and in the best interest of the Company, an affiliate of SMH and included as part of the Transaction, to approve the Transaction and Transfer Agreement as attached hereto as Exhibit A as related to the Company; and further

RESOLVED, that the Transaction and the Transfer Agreement contemplated herein as they relate to the Company are hereby approved by the Directors and the Shareholders; and further

RESOLVED, that Steven E. Schneider, M.D., the President of the Company ("Authorized Officer"), be, and hereby is, authorized to negotiate, execute and deliver in the name of the Company all such applications, licenses, registrations, agreements, instruments, documents and all such other Transaction-related 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 the Company, in connection with obtaining all regulatory approvals, licenses, permits, consents, certificates, determination letters or other authorizations necessary or advisable to consummate the Transaction as it relates to the Company, the execution and delivery of which shall be conclusive evidence of such Authorized Officer's approval thereof and authority hereunder; and further

RESOLVED, that the Authorized Officer be and hereby is authorized to negotiate, execute and deliver all such instruments and documents, make all such payments, make all such filings and do all such other acts and things as in his opinion may be necessary or appropriate in order to carry out the intent and purposes of the foregoing resolutions; and that all such acts and things heretofore done by such Authorized Officer in connection with and in furtherance of the purposes and intent of the foregoing resolutions be, and they hereby are, ratified, confirmed and approved as the act and deed of the Company; and further

RESOLVED, that all actions hereto taken by any director, any officer or any agent of the Company in the name or on behalf of the Company in connection with or otherwise in contemplation of the matters contemplated by the foregoing resolutions, be, and each of the same hereby is, adopted, ratified, confirmed and approved in all respects as the act and deed of the Company.

[Remainder of page intentionally blank; signature page follows.]

Exhibit A

Transfer Agreement

See Attached

62409892 v1-WorkSiteUS-080456/0034

IN WITNESS WHEREOF, the undersigned, being all of the Directors and Shareholders of the Company, have executed this Unanimous Written Consent (which may be executed in counterparts) as of date first set forth above.

DIRECTORS:

Garrett Casey

James Uberti, M.D.

J. Alexander Palesty, M.D.

Rohit Beri, M.D.

Steven Schneider, M.D.

Philip Corvo, M.D.

Jason Ouellette, M.D.

John Testa, M.D.

Michael Novak

Laura Brenes-Dorso, M.D.

Chad Wable

SHAREHOLDERS:

Michael Simms, M.D.

James Uberti, M.D.

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Jason Ouellette, M.D.

John Testa, M.D.

Michael Novak

Laura Brenes-Dorso, M.D.

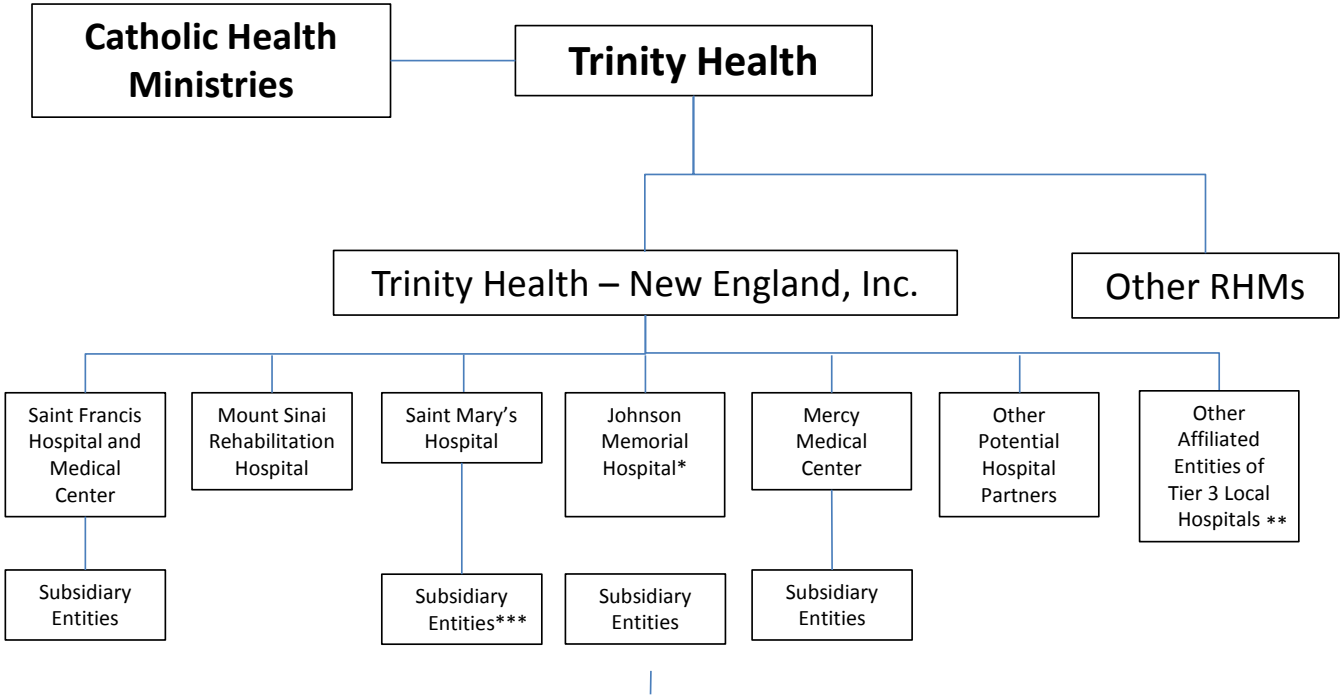
Chad Wable

SHAREHOLDERS:

Michael Simms, M.D.

James Uberti, M.D.

EXHIBIT 2



*(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.

***Franklin Medical Group. P.C. would be included as a subsidiary entity of Saint Mary's Hospital upon approvals.

EXHIBIT 3

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 4

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;

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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 5

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

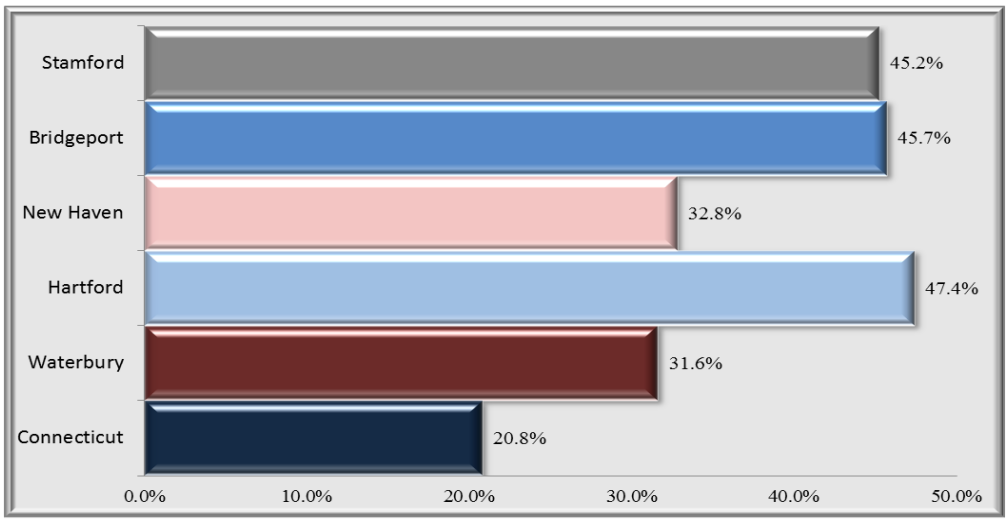


Figure 1. Percentage of population speaking a language other than English, 2009-2011
Source: U.S. Census Bureau, 2012

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).

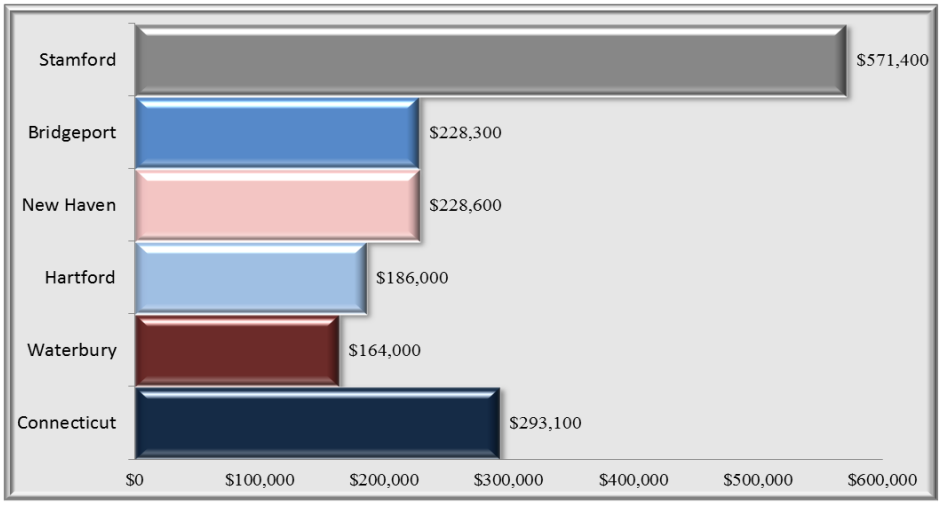


Figure 2. Median value for owner-occupied unit, 2009-2011
Source: U.S. Census Bureau, 2012

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).

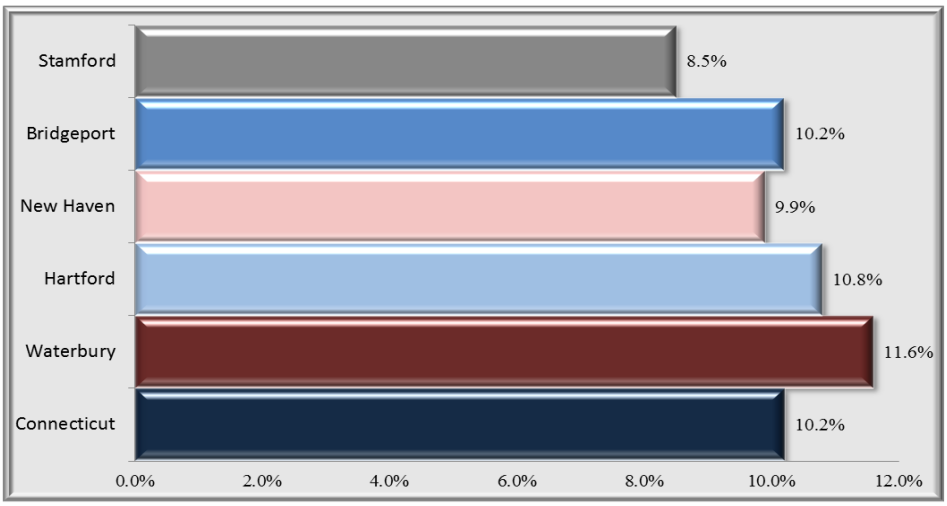


Figure 3. Divorce Rate, 2009-2011
Source: U.S. Census Bureau, 2012

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.).

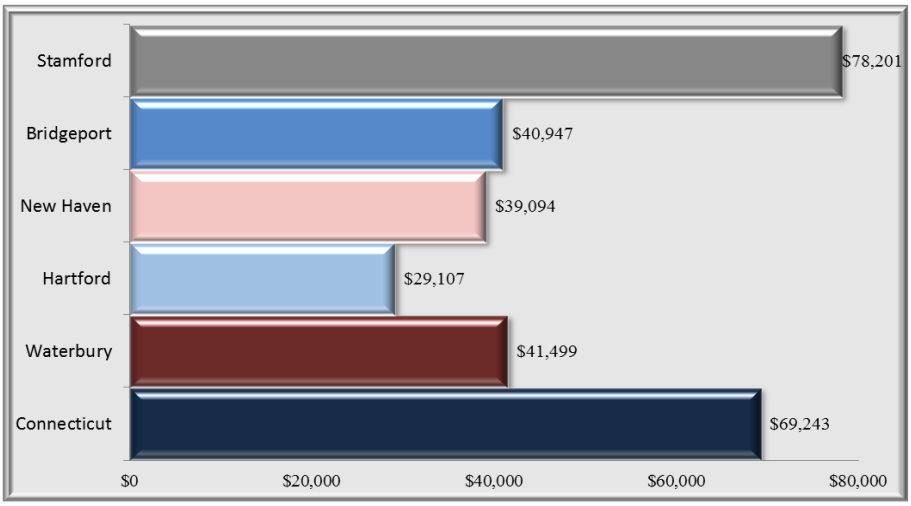


Figure 4. Median household income, 2009-2011
Source: U.S. Census Bureau, 2012

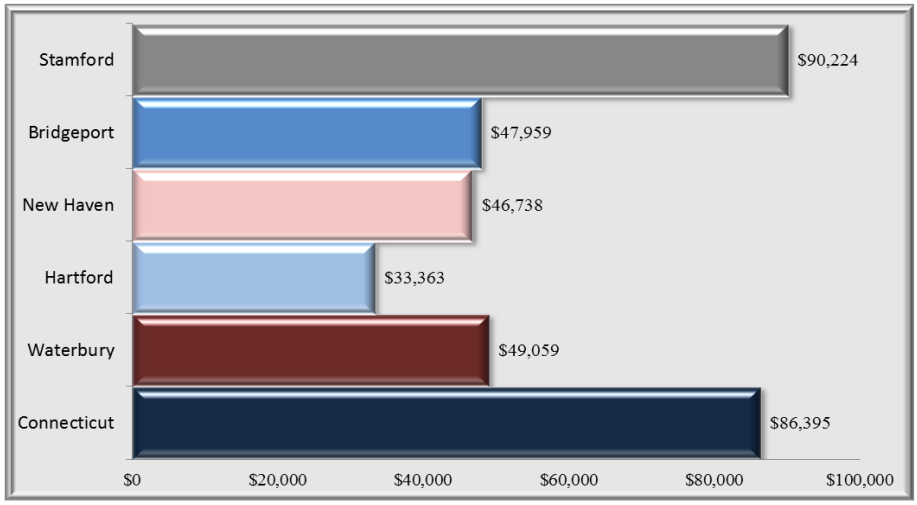


Figure 5. Median family income, 2009-2011
Source: U.S. Census Bureau, 2012

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.

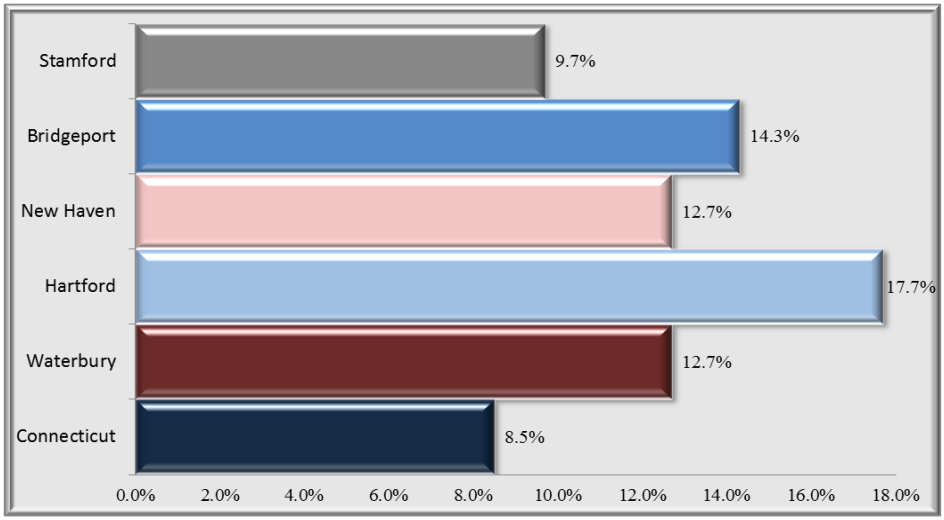


Figure 6. Unemployment rate for civilian labor force, 2009-2011
Source: U.S. Census Bureau, 2012

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).

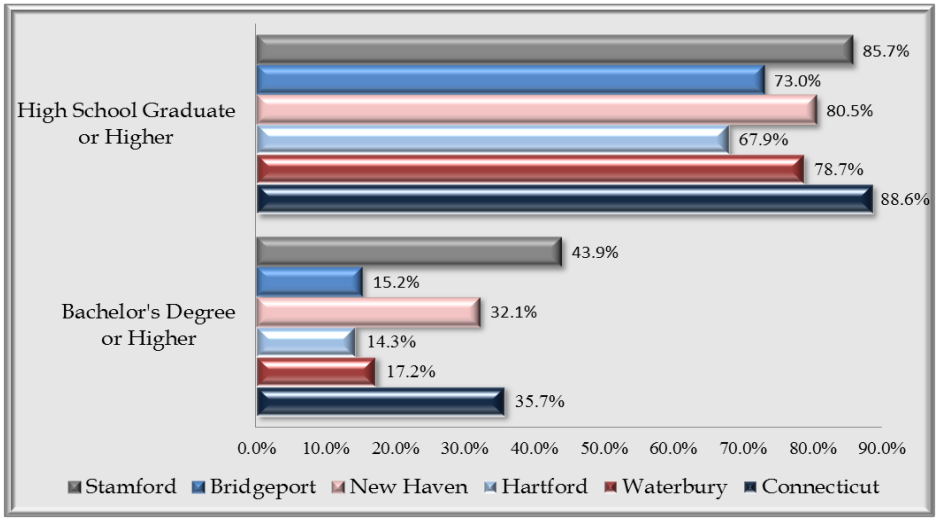


Figure 7. Educational attainment, 2009-2011
Source: U.S. Census Bureau, 2012

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).

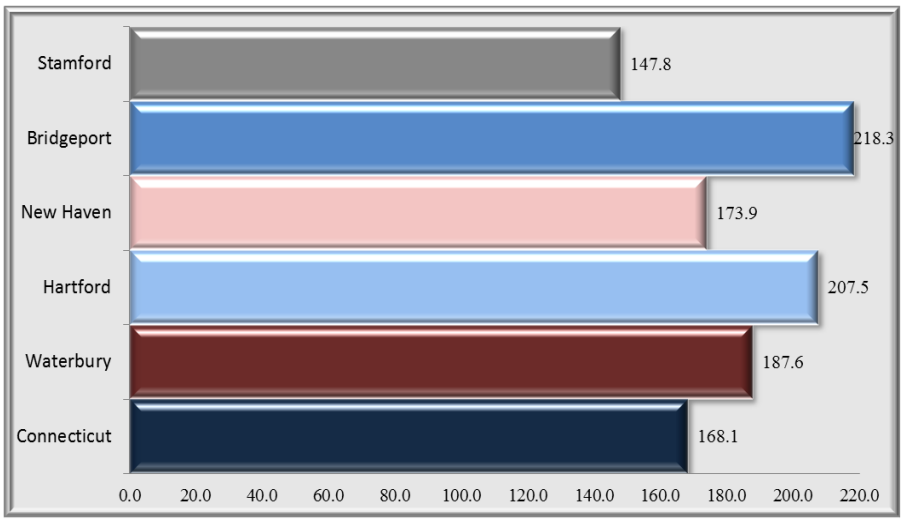


Figure 8. Deaths due to diseases of the heart per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

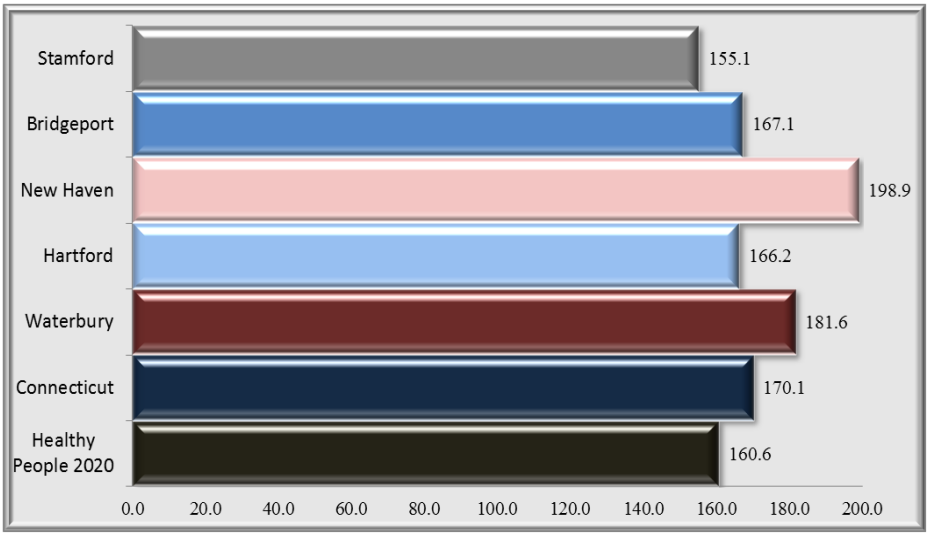


Figure 9. Deaths due to malignant neoplasms (cancer) per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011; Healthy People 2020, 2012;
Connecticut Department of Public Health, n.d.

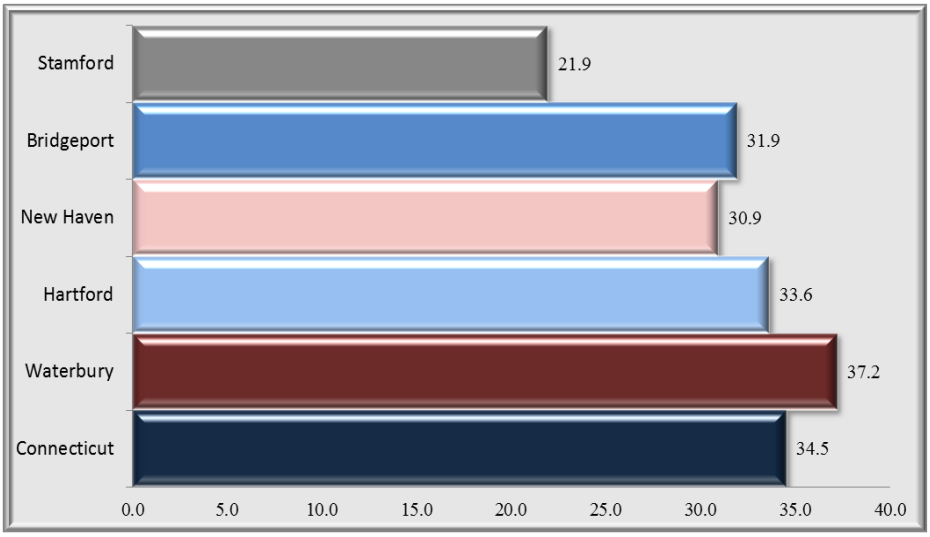


Figure 10. Deaths due to chronic lower respiratory disease per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

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).

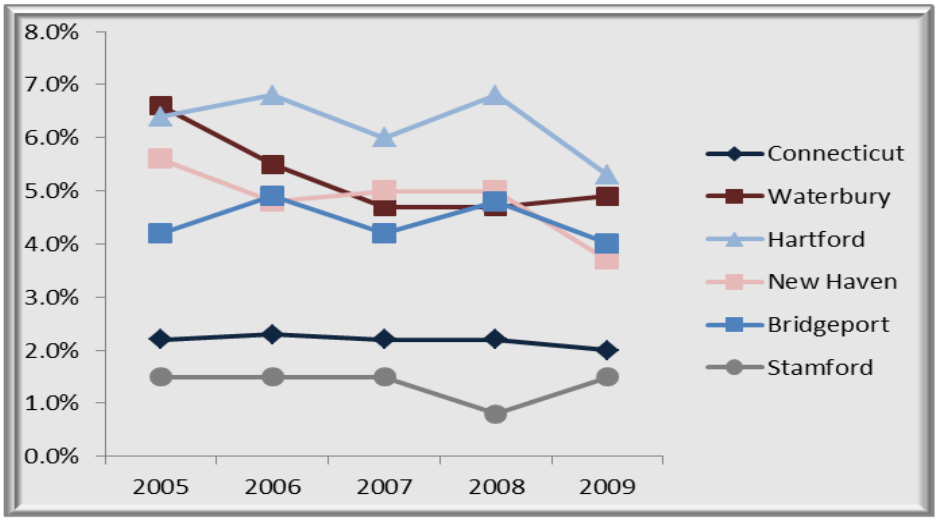


Figure 11. Births to teenagers less than 18 years, 2005 - 2009
Source: Connecticut Department of Public Health, 2007 - 2011

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).

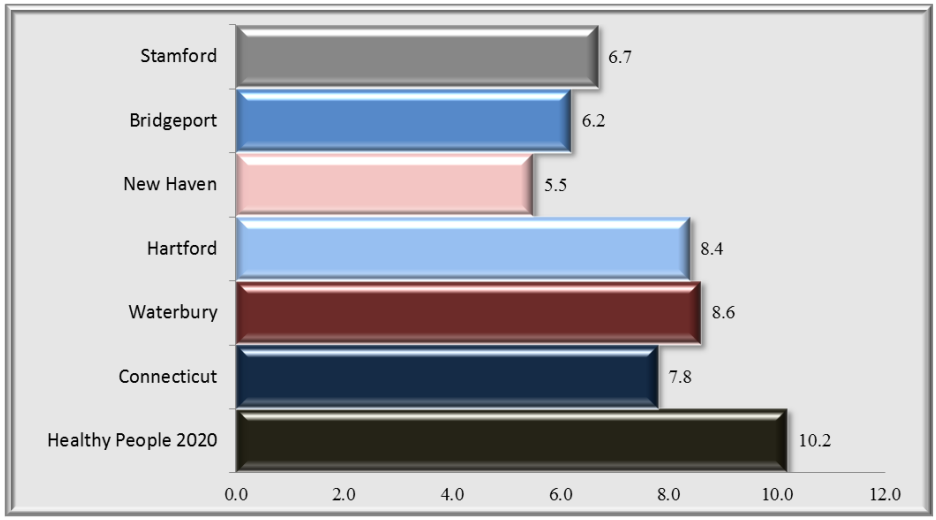


Figure 12. Suicide rates per 100,000, 2005 - 2009
Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

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.

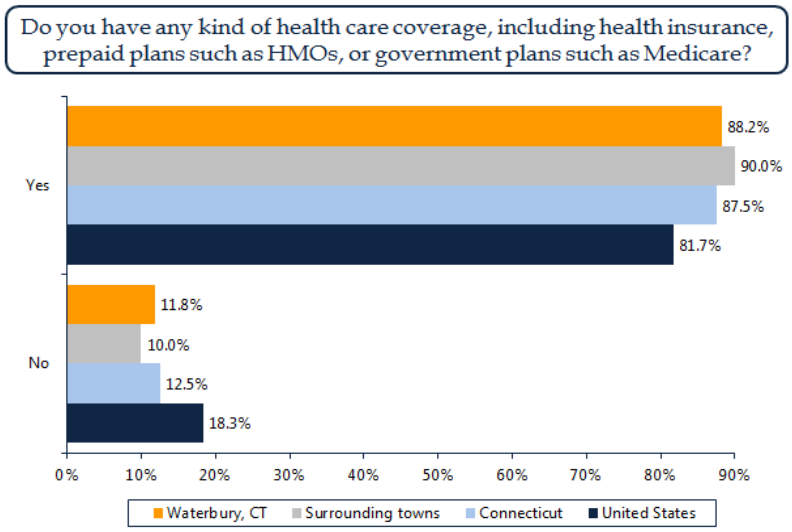
Statistical considerations for the study can be found in Appendix B. The following section provides a summary of the Household Telephone Survey results. A full report of the Household Telephone Survey results is available in a separate document.

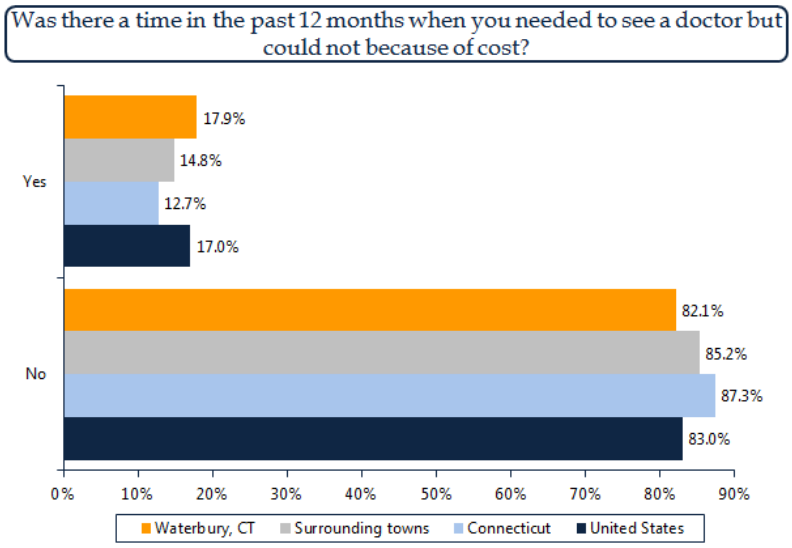
Household Telephone Survey Key Findings

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.

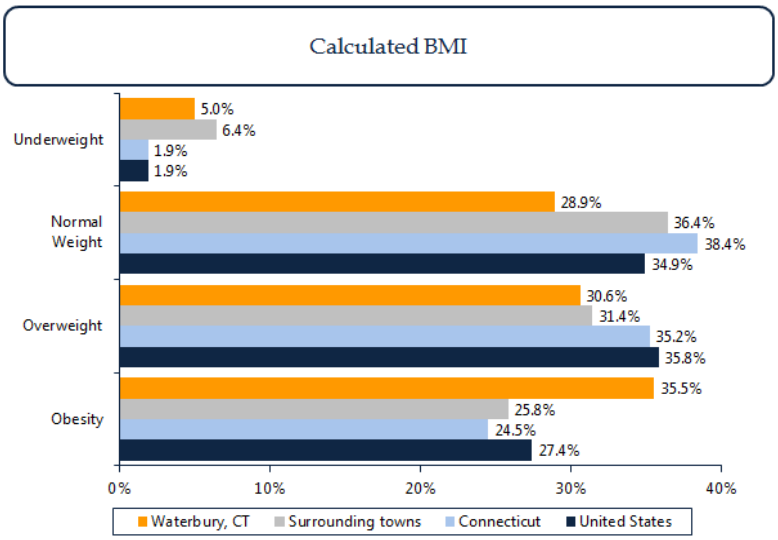




Health Risk Factors

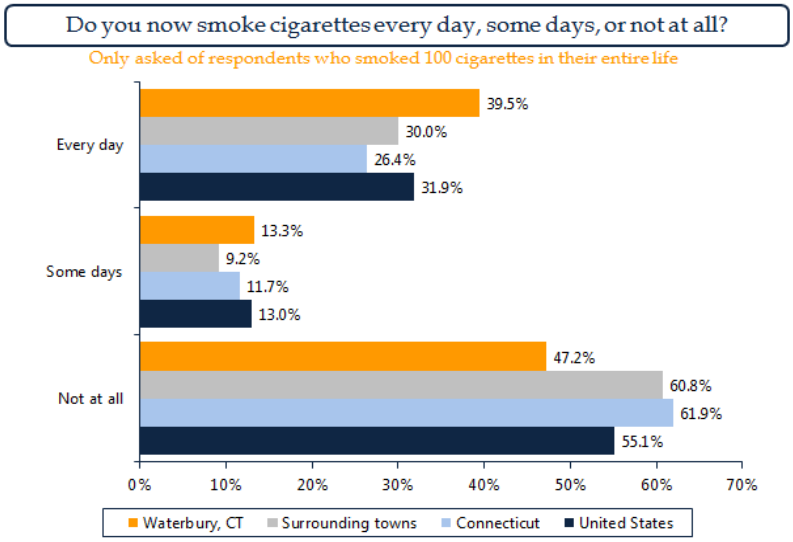
Obesity & Physical Activity

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%).

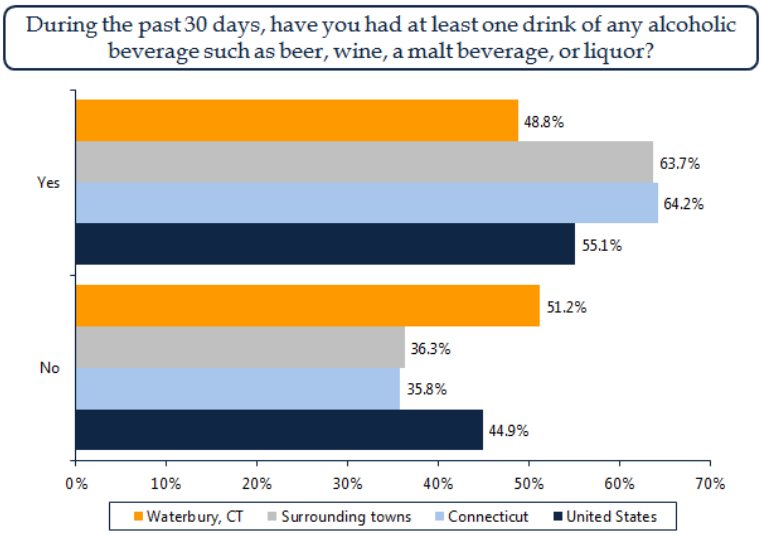


Tobacco & Alcohol Use

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.



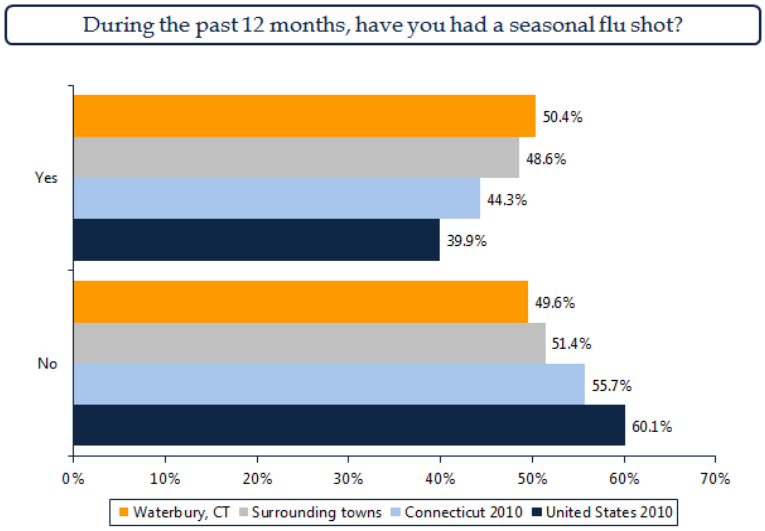
Alcohol use and abuse is not as prevalent. Only 48.8% of respondents had an alcoholic beverage during the past 30 days compared to 64.2% across Connecticut and 55.1% across the nation. Of the individuals who did consume alcohol, fewer did so on a daily basis or participated in binge drinking, and more than half had a maximum of one to two drinks at a time.



Preventive Health Practices

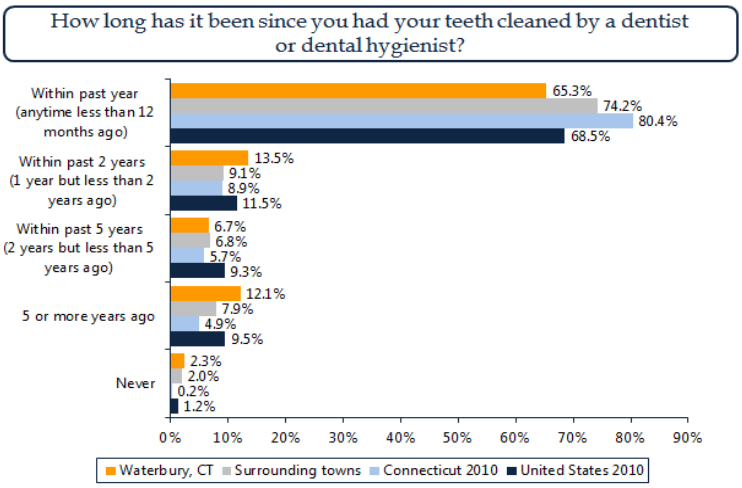
Immunizations

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.

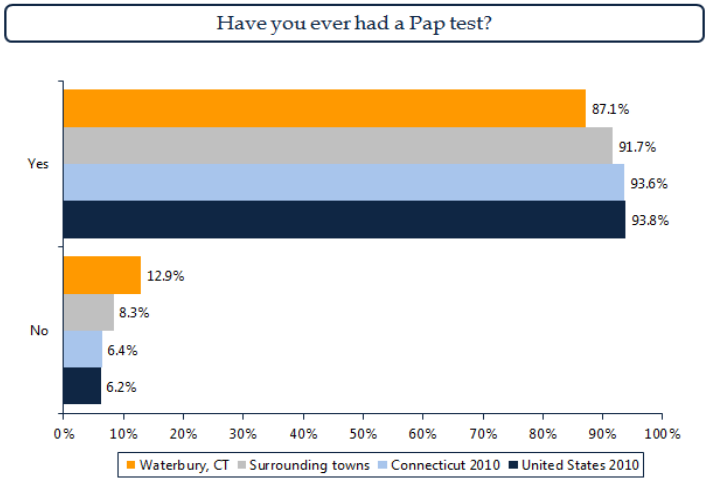


Screenings

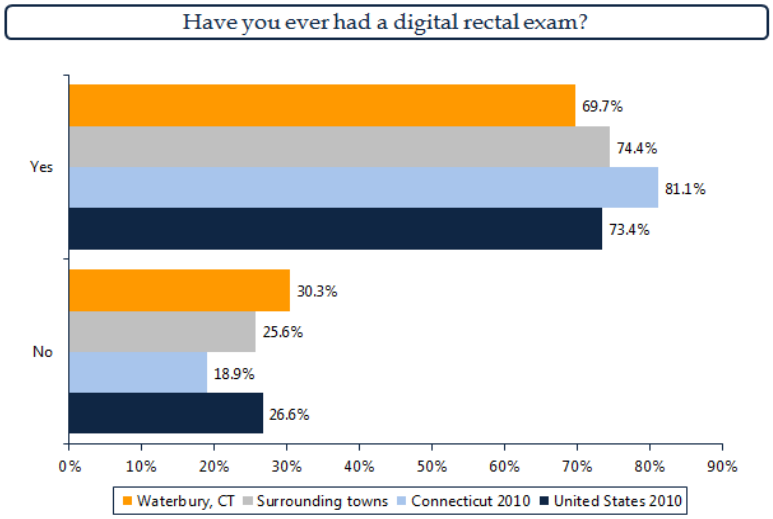
In general, Waterbury residents are less likely to engage in preventative oral health practices. Only 60.8% of respondents visited a dentist or a dental clinic within the past year. This is consistent with the nation (68.1%), but notably lower when compared to Connecticut (80.6%). Waterbury respondents 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%).

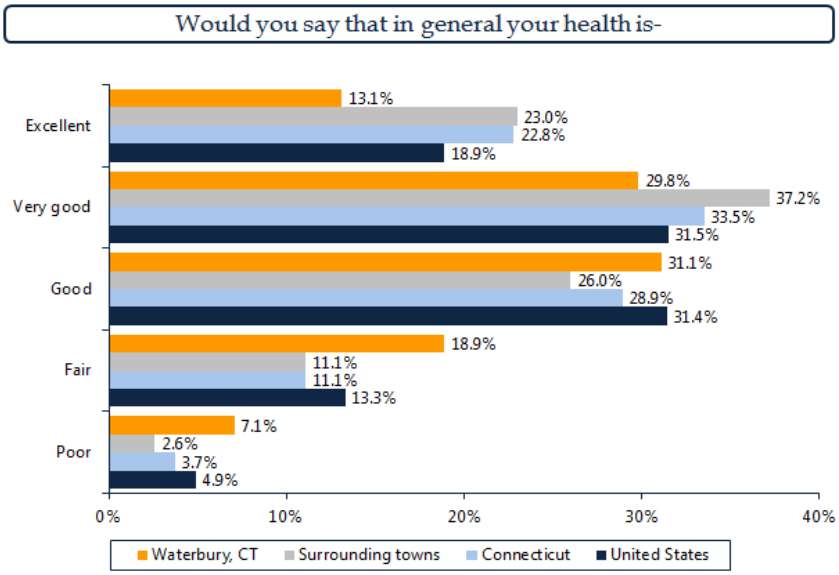
Residents in Waterbury are more likely to have been tested for HIV (55.7%) when compared to residents across Connecticut (36.7%) and the nation (37.4%). By itself, this is a positive finding. However, additional data suggests that a possible reason for higher screening rates is the prevalence of high 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.

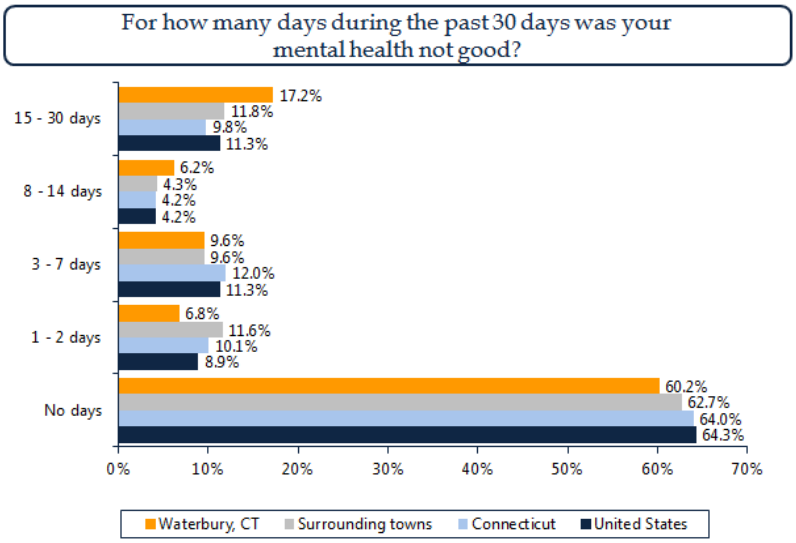
Health Status & Chronic Health Issues

Physical & Mental Health

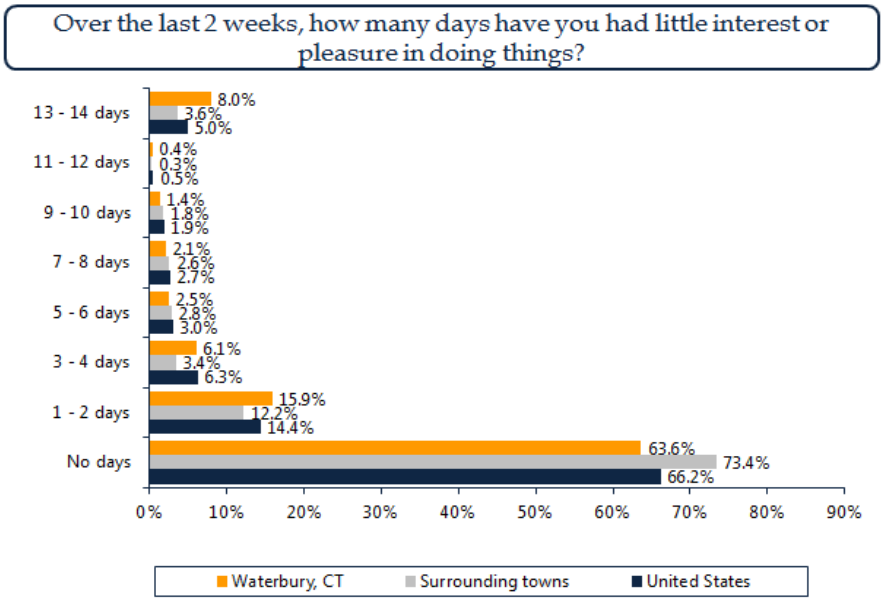
Residents of Waterbury are more likely to report having fair or poor health in general. Only 13.1% of respondents said that their health was excellent, compared to Connecticut (22.8%) and

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.





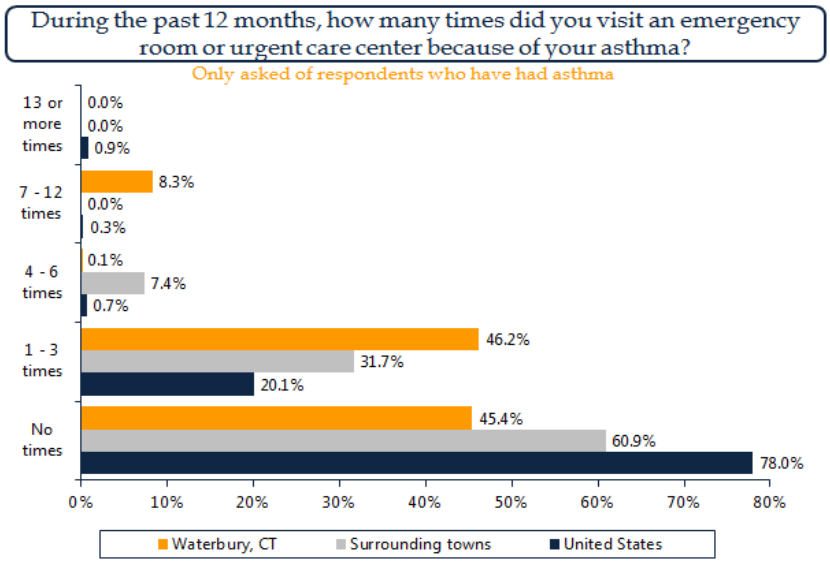
In addition to having more days of poor mental health, Waterbury respondents are more likely to have been diagnosed with an anxiety disorder and to have felt depressed and had little interest in doing things. The percentage of Waterbury respondents who have been diagnosed with an anxiety disorder is 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%).



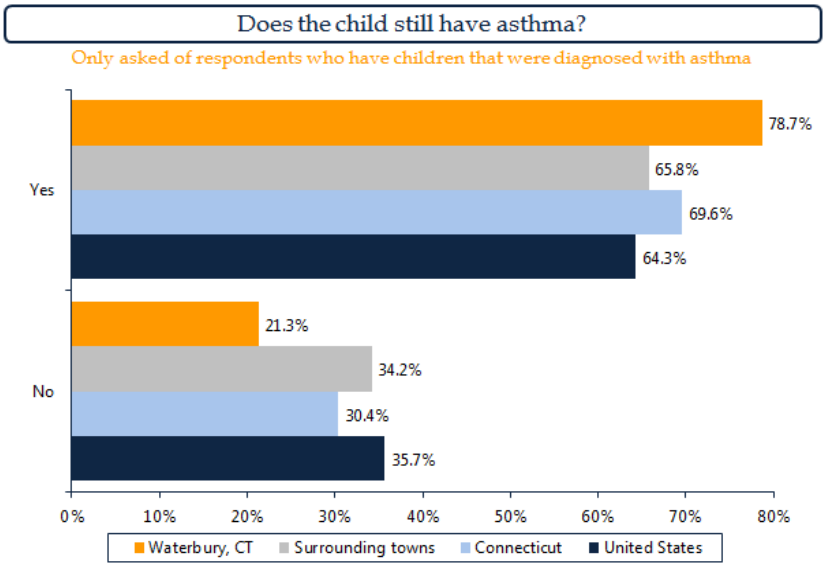
A contributing factor to the poor mental health status of Waterbury residents may be the proportion of residents who are acting as caregivers for friends or family members. During the past month, 27.1% of respondents provided caregiver services compared to 15.6% across Connecticut and 16.8% across the 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%).

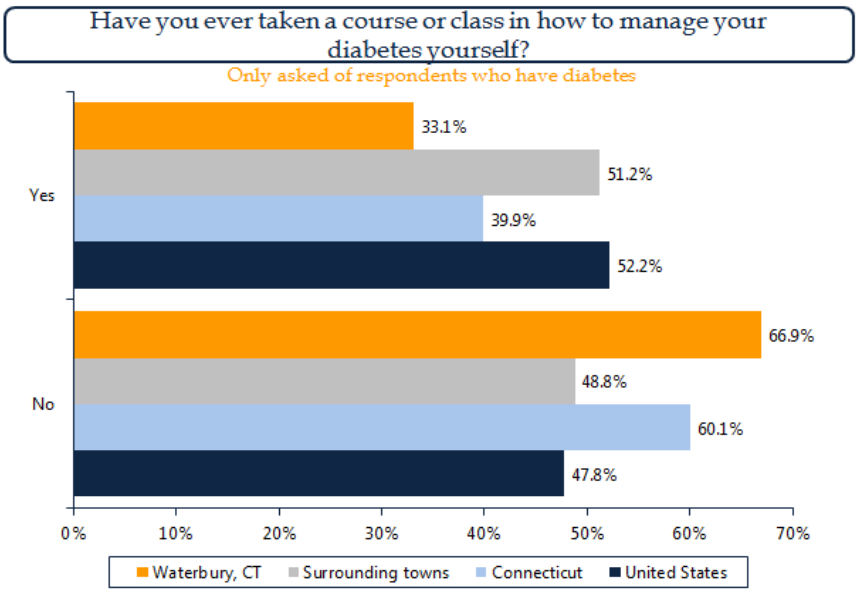


Children in Waterbury are also disproportionately affected by asthma. Slightly more than 21% have been diagnosed with asthma compared to 15.0% in Connecticut and 13.4% in the nation. They are also more likely to still have asthma (78.7%) when compared to Connecticut (69.6%) and the nation (64.3%).



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?"

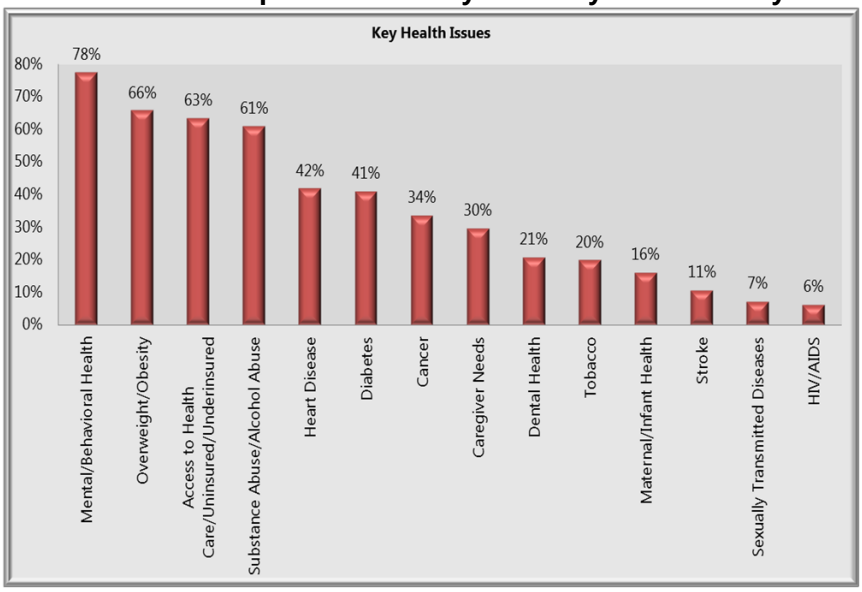


Figure 1: Ranking of key health issues

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.

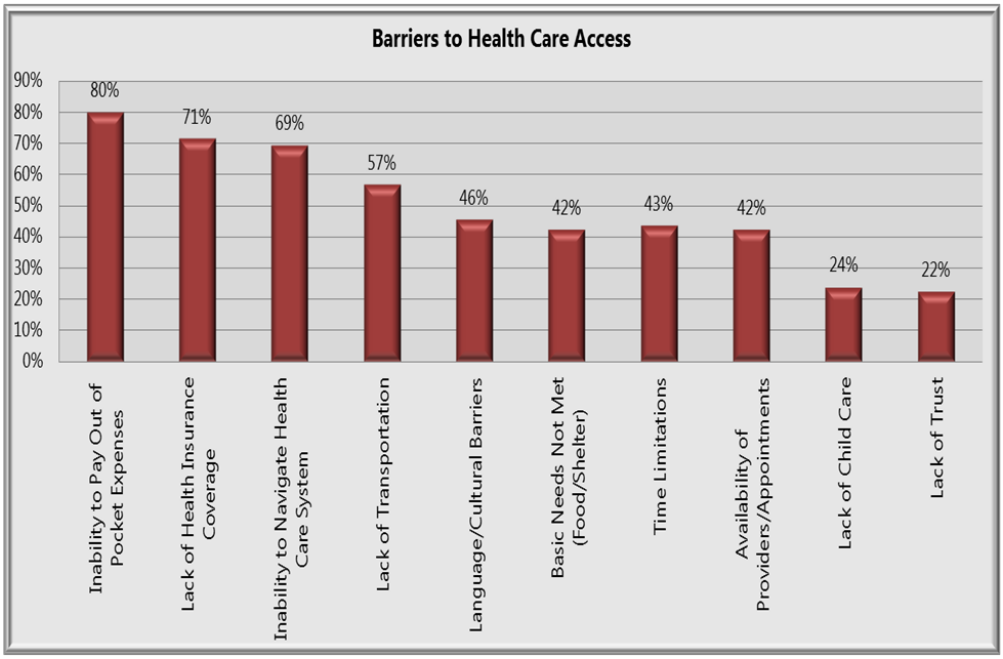


Figure 2: Ranking of barriers to health care access

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?"

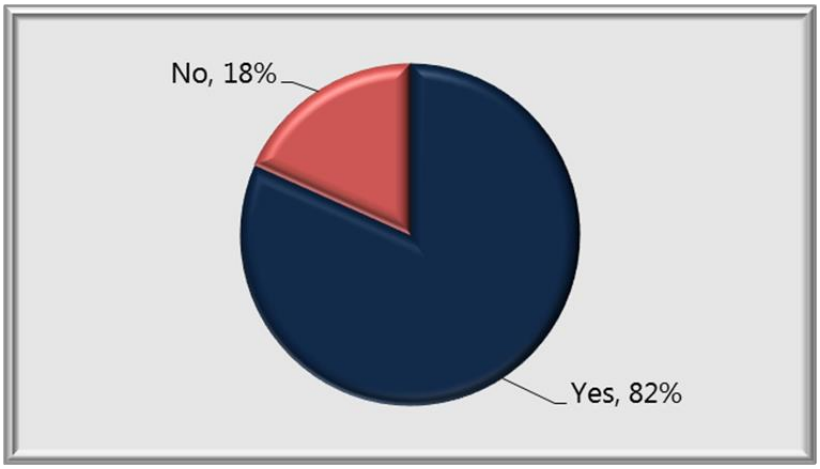


Figure 3: Key informant opinions regarding underserved populations

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?

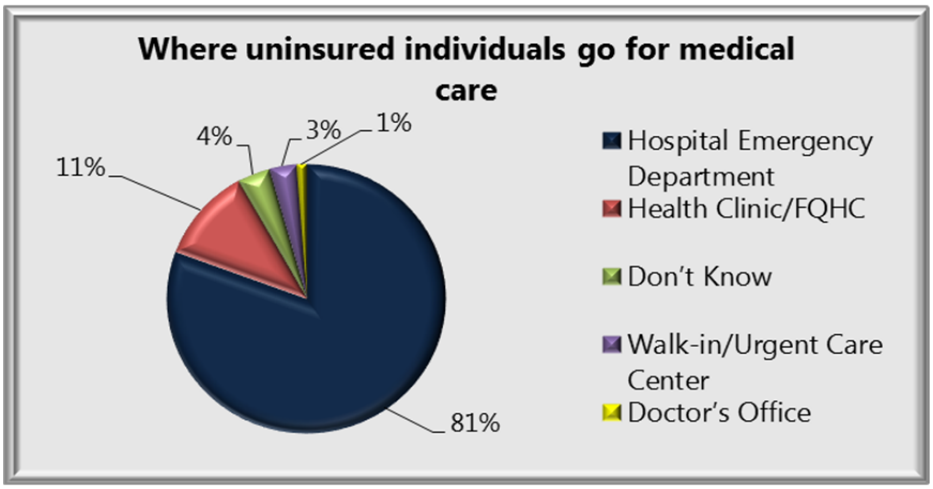


Figure 4: Key informant opinions of where uninsured individuals receive medical care

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

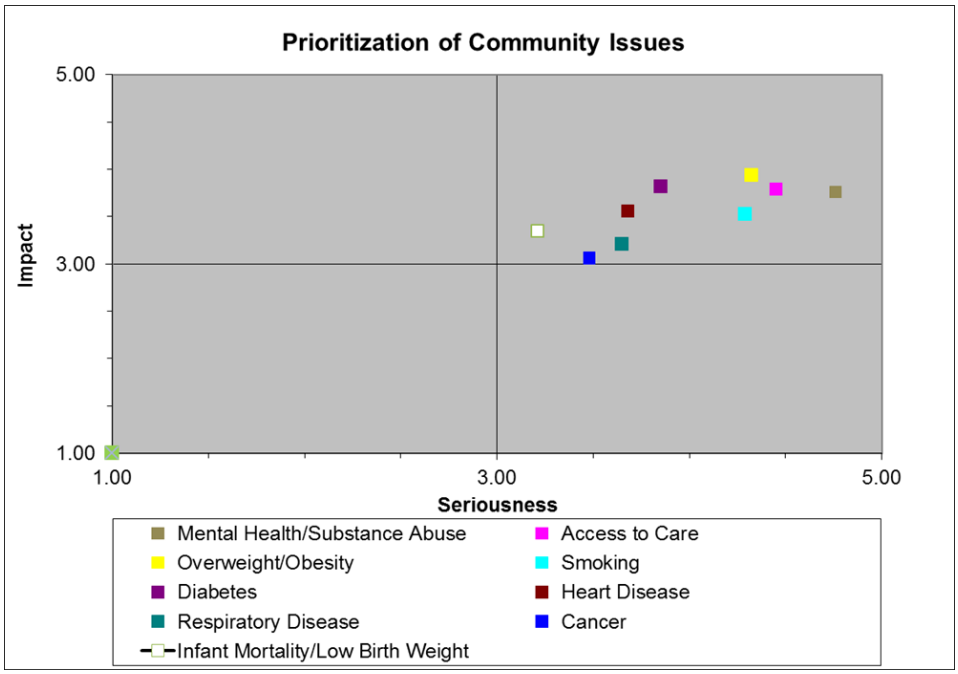
Key Community Health Issues

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

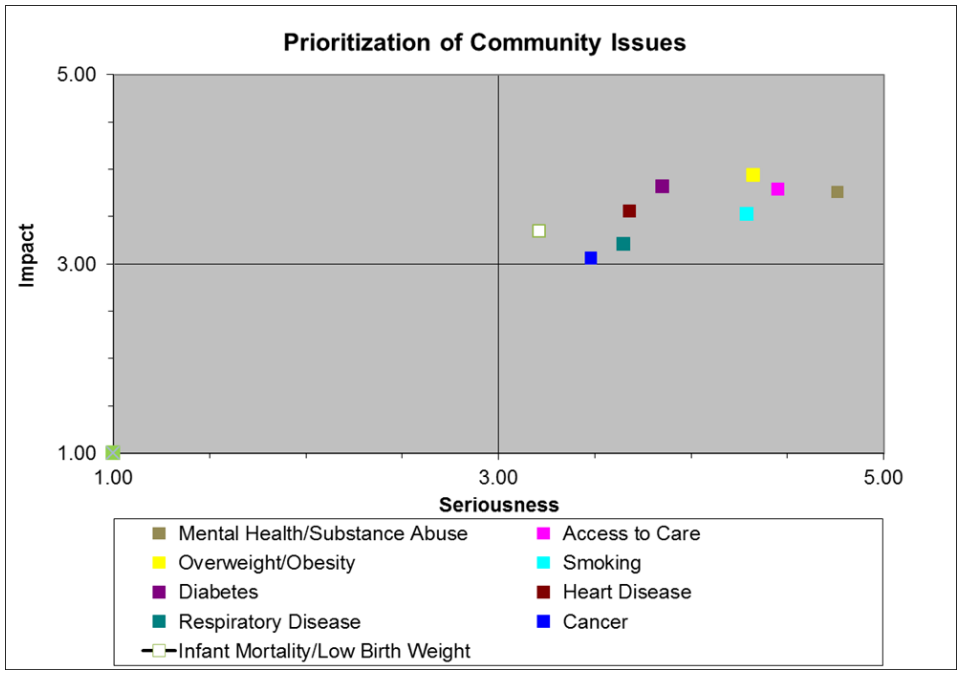
Key Community Health Issues

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 6

Saint Mary's Strategic Plan 2016-2020

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Introduction and overview

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

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

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

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

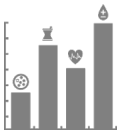
Long Term (3-5 Year) Initiatives

- 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 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

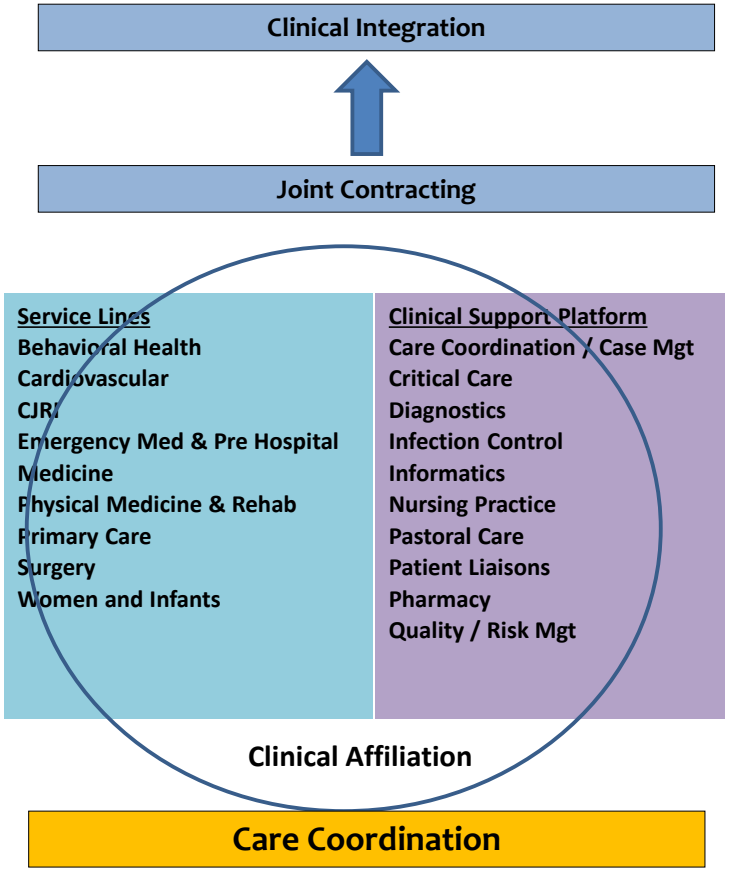
Innovation & Learning
- Education
- Innovation
- Leadership Development
- Library
- Performance Improvement
- Research
- SFC Solution System
- Simulation

Facilities
- Biomedical
- Engineering
- Food Services
- Housekeeping
- Laundry
- Security
- Space Management
- Transport

focus on Patient Experience runs through all

EXHIBIT 8

SFC Alliance Approach



Business & Support Platforms

Business and Services

Business Development	IT
Compliance	Legal / Regulatory
Enterprise Risk Mgt	Marketing / Comm
Finance / Audit	Mission Integration
Government Relations	Strategic Planning
Human Resources	Supply Chain

Facilities

Biomedical	Laundry
Engineering	Security
Food Services	Space
Housekeeping	Management
	Transport

Innovation + Learning

CIPCI	PI
Education	Research
Innovation	SFC Solution
Leadership Dev.	System
Library	Simulation

Coordinated Support

EXHIBIT 9

SAINT FRANCIS
AWARDS AND RECOGNITIONS

CareChex – Saint Francis Hospital and Medical Center has been recognized by CareChex®, a division of Comparion Medical Analytics, for national and state medical excellence achievements in numerous categories in its 2016 hospital quality award rankings. For the national scorecard, Saint Francis was greater than the 90th percentile in the clinical category of joint replacement for an overall rating and also for mortality overall, complications overall and patient safety. (January 2016/for internal use only)

CareChex – Saint Francis Hospital and Medical Center has been recognized by CareChex®, a division of Comparion Medical Analytics, for national and state medical excellence achievements in numerous categories in its 2016 hospital quality award rankings. (January 2016/for internal use only)

For the national scorecard, Saint Francis was greater than the 90th percentile in the clinical category of orthopedic surgery for an overall rating and also for mortality overall, complications overall and patient safety. Saint Francis was also first in Connecticut for this category.

In the medical excellence award summary, Saint Francis was ranked in the following categories:

- Nationally: Top 100 in joint replacement, major neurosurgery and major orthopedic surgery. Top 10% in joint replacement, neurological care, major neurosurgery and major orthopedic surgery.
- Regionally: Top 10% in overall hospital care, joint replacement, neurological care, major neurosurgery, orthopedic care and major orthopedic surgery.
- State: #1 in joint replacement, neurological care, major neurosurgery, orthopedic care, and major orthopedic surgery. Top 10% in overall hospital care, joint replacement, neurological care, major neurosurgery and major orthopedic surgery.
- Market: #1 in joint replacement, neurological care, major neurosurgery, major orthopedic surgery and stroke care.

In the patient safety award summary, Saint Francis was ranked in the following categories:

- Nationally: Top 100 in hip fracture repair and joint replacement. Top 10% in overall hospital care, overall surgical care, heart attack treatment, hip fracture repair, joint replacement, neurological care, major neurosurgery, orthopedic care, major orthopedic surgery, pneumonia care, stroke care and women's health.
- Regionally: Top 10% in overall hospital care, overall surgical care, heart attack treatment, hip fracture repair, joint replacement, neurological care, major neurosurgery, orthopedic care, major orthopedic surgery, pneumonia care, stroke care and women's health.
- State: #1 in overall hospital care, overall surgical care, joint replacement and stroke care. Top 10% in overall hospital care, overall surgical care, hip fracture replacement, joint replacement, neurological care, major neurosurgery, orthopedic care, major orthopedic surgery, pneumonia care, stroke care and women's health.
- Market: #1 in overall hospital care, overall surgical care, coronary bypass surgery, joint replacement, neurological care, major neurosurgery, orthopedic care, major orthopedic care, and stroke care.

Healthgrades® – Saint Francis 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 *earned the Distinguished Hospital Award for Clinical Excellence in 2016.* (January 2016)

2016 Women's Choice Awards – Saint Francis Hospital and Medical Center has received three Women's Choice Award from WomenCertified®, distinguishing it in the following categories: America's Best Hospitals for Bariatric Surgery, America's Best Hospitals for Heart Care and America's Best Breast Centers. The awards are 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. (Embargo January 2016)

U.S. Department of Health and Human Services (HHS) Gold Award – Saint Francis Hospital and Medical Center is among a select group of hospitals and transplant centers nationwide recognized by the U.S. Department of Health and Human Services (HHS) for reaching gold, silver, or bronze levels of achievement by conducting activities that promoted enrollment in state organ donor registries. The hospitals are part of the national Workplace Partnership for Life (WPFL) Hospital Campaign, sponsored by HHS's Health Resources and Services Administration (HRSA). Saint Francis received the gold designation and is currently working toward the newly-added platinum level for 2016. (November 2015)

Becker's Hospital Review – Saint Francis Hospital and Medical Center was named in Becker's 2015 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. (November 2015)

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 *America's Best Stroke Centers*. The award is given to hospitals that carry the certification of an Advanced Primary Stroke Center or Advanced Comprehensive Stroke Center by the Joint Commission combined with achieving above average patient recommendation 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. (Internal Only – May 2015)

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. Saint Francis is one of only two Connecticut hospitals to receive "Straight A" recognition since the program's inception in 2012. Leapfrog has also cited the 182 hospitals nationwide that have consistently received an "A" grade for safety with a "Straight A's" logo on its Hospital Safety Score website. In addition to Saint Francis, three other Connecticut hospitals earned the highest A rating in the most recent review; three hospitals received "B" ratings; 18 a "C" rating; and one a "D" rating. Across the country, 782 hospitals received an "A" grade. Of the 26 Connecticut hospitals scored, 21 stayed the same, two improved, and three worsened. (April 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 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. (Internal Only: 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, Embargo 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* has 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* has been 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 again 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 latest 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, has 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 has been 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 has 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 has 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 marks the second consecutive year that Saint

Francis has been recognized with the *Gold Plus* quality achievement award. Saint Francis is one of just three hospitals in Connecticut to receive *Gold Plus* recognition this 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 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 has been 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 this 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. released today. 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 has 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 places 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 is the third consecutive year that Saint Francis has received this prestigious award and 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 has 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* has been 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 is 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 new 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 recognizes 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 – was 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 is one of the 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℠ 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℠ – 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 is 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 is the third year in a row that Saint Francis has 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 places 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 is 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 have been 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 is the second year in a row that Saint Francis has 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 is 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 places 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 is 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 is 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 is the first year that the award is being given to an individual or organization who has demonstrated exceptional collaboration to further the educational goals and mission of the College. Saint Francis is one of two recipients being honored this 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 99th 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.

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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,

Vicky Cipriano/af

Victoria Cipriano
Recording Secretary

Approved by,

Robert J. Mazaika
Chairman of the Board

EXHIBIT 11

- Started Saint Mary's PHO and ACO with contracts pending from two commercial payors and the MSSP application pending. Built entire infrastructure for management and governance
- Took over leadership of Case Management and instituted changes resulting in 0.5 day decrease in ALOS over 6 months

***Waterbury Hospital* – Waterbury, Connecticut** **1989 – 2011**

Waterbury Hospital Description:

- 15,000 admissions, 10,000 surgical procedures 56,000 ED visits per year
- Not for profit, community hospital
- Residencies in Internal Medicine (Yale Affiliated) and General Surgery (Yale and UCONN Affiliated)
- Level 2 Trauma Center
-

Direct Reports at Waterbury Hospital:

- Chairs of All Medical and Surgical Departments
- Director of Emergency Department Nursing
- Director of Case Management
- Chief Quality and Safety Officer
- Director of Marketing and Community Relations
- President of Alliance Medical Group (Hospital owned multispecialty physician group)
- Chief Medical Officer of Alliance Medical Group
- Director of Managed Care Contracting (from 1995-2000)

Accomplishments:

V.P. for Medical Affairs/Chief Medical Officer (WH) **1994 - Present**

- Chair, Board of Directors, Heart Center of Greater Waterbury:
    - Led, along with many others, the creation and approval of the first new Open Heart Surgery and Angioplasty program approved in Connecticut in nearly 20 years;
    - First program approved as a joint program between 2 competing hospitals
    - As Chair, successfully worked with members of the 2 hospital consortium through a very challenging Certificate of Need process

- Leadership of hospital marketing, advertising, and community relations departments:
  - Created very successful campaign marketing Orthopedic services with more than half of joint replacements coming from areas beyond our primary and secondary service areas
  - Developed, in conjunction with a partnering hospital, a huge and successful multimedia, community grass roots, and political strategy and campaign to win approval for a joint open heart and angioplasty program
- Created one of the first Hospitalist programs in Connecticut:
  - 10 years in operation; grown from 5 to 15 physicians
  - Covers more than half of all inpatients
  - Superior ALOS and quality parameters compared with private service
  - and teaching service patients
- Built and led hospital – owned physician group:
  - Grown over 15 years from a 4 physician primary care group to a Multispecialty group of more than 50 physicians and surgeons
  - Annual revenues of >$15 million; cost per physician lower than the 25th percentile MGMA benchmark
- Started Waterbury Hospital's case management program:
  - Greater than 10 year track record of shortened lengths of stay
  - Greatly improved clinical documentation accuracy with revenue improvements of greater than $1 million per year
- Oversaw managed care contracting on behalf of Waterbury Hospital and the 300 plus physicians in a PHO
- Led complete turnaround of Physician and Nursing Leadership and all Physician staff of the Waterbury Hospital Emergency Department:
  - Changed from no EM Board Certified physician to All EM Board Certified
  - ED volume grew from 40,000 visits to over 56,000 visits per year
  - ED now has a positive contribution margin of $5-$10 million annually

Chairman Department of Psychiatry 1989-1994

- Full operational and budget responsibility for all aspects of a very large program with greater than 50,000 outpatient visits and 1000 inpatient admissions per year
- Redesigned department from one large service to sub-specialty service lines leading to significant improvements in service quality and in payor mix

- Implemented aggressive utilization management and clinical pathways leading to the publication of an article in a peer reviewed journal featuring our specialty ultra-short length of stay inpatient unit

***Allegheny General Hospital* – Pittsburgh, Pennsylvania** **1985-1989**

Acting Medical Director, Allegheny Neuropsychiatric Institute 1988-1989

- Assumed leadership of Allegheny Neuropsychiatric Institute (ANI), a freestanding subsidiary of Allegheny General Hospital at the request of AGH CEO after unexpected departure of both AGH's Department Chair/Founder of ANI and the Medical Director of ANI just after the facility opened.
    - Brought stable leadership to a very chaotic situation
    - Provided credible clinical programming to external referring hospitals
    - Recruited excellent clinical staff in a challenging environment

Chief, Inpatient Psychiatry Allegheny General Hospital/Medical College of Pennsylvania 1985-1988

- Facilitated growth of Inpatient Service from 16-28 beds
- Led change in treatment approaches toward more practical and modern neuropsychiatric and biologic treatment protocols

United States Army Medical Officer **1977-1982**

- Attained rank of Major, U.S. Army Medical Corps

***Martin Army Hospital* – Ft. Benning, Georgia** **1980-1982**

Chief, Emergency Medicine Service

- Totally restructured E.R. service organization resulting in dramatic improvement in quality and efficiency of services
- Awarded Army Commendation Medal for the above
- Introduced Advanced Trauma Life Support Courses and Certification to the hospital
- Established respected Family Practice resident rotation in Emergency Medicine

Ft. Lewis/Madigan Army Medical Center – Ft. Lewis, Washington **1978-1979**

Brigade Surgeon, 9th Infantry Division, 3rd Brigade

Education:

1994-1995	University of New Haven, MBA
1982-1985	Yale University School of Medicine, Residency in Psychiatry
1979-1980	Madigan Army Medical Center, Residency in Emergency Medicine
1977-1978	Madigan Army Medical Center, Internship, pre Emergency Medicine
1974-1977	University of Nebraska, College of Medicine, MD
1970-1974	University of Nebraska BA Biology, Magna Cum Laude

Licensure and Certification:

Connecticut Medicine and Surgery
American Board of Psychiatry and Neurology

Academic Publications:

Schneider, SE and Ross, IM. The Effectiveness of Ultra-Short Length of Stay Admission in a Comprehensive Managed Care System. Psychiatric Services, Vol. 47: No. 2, p. 137-138, 1996.

Schneider, SE and Phillips, WM. Depression and Anxiety in Medical, Surgical, and Pediatric Interns. Psychological Reports. 72:1145-1146, 1993.

Yudofsky, SC, Silver, JM, Schneider, SE. The Use of Beta Blockers in the Treatment of Aggression. Psychiatry Letter. Fair Oaks Hospital. Spring/Summer, Vol. 6, Issue 1-6, 1988.

Yudofsky, SC, Silver, JM, Schneider, SE. Pharmacologic Treatment of Aggression. Psychiatry Annals. 17, (6): 397-407, 1987.

Academic Positions:

Assistant Clinical Professor of Psychiatry, Yale University	1991-2000
Adjunct Clinical Assistant Professor, Quinnipiac College	1997-2002
Assistant Professor of Psychiatry, Medical College of Pennsylvania	1987-1989
Clinical Instructor in Emergency Medicine, US Army Academy Of Health Sciences	1981-1982

Professional Organization:

American College of Healthcare Executives
American College of Physician Executives
American Medical Association
Waterbury Medical Society

Community Activities:

Past Trustee Waterbury YMCA
Volunteer Mentor in Waterbury School System
Member of Visions Task Force, City of Waterbury
Past Acting Director of Health Department, City of Waterbury
Incorporator, Child Guidance Clinic of Waterbury

JOHN ANTHONY TESTA

166 Waterbury Road Suite 300, Prospect, CT | 203-709-5300 | john.testa@stmh.org

EDUCATION

Yale University School of Medicine
Clinical Instructor of Medicine — **2004-2009**
New Haven, CT

University of Connecticut School of Medicine
Assistant Clinical Professor of Medicine — **2003-Present**
Farmington, CT

Board Certification, American Board of Internal Medicine — **2003-Present**

University of Connecticut
Primary Care/ Internal Medicine — **1999-2002**
Farmington, CT

Ross University School of Medicine — **1993-1999**
Dominica, West Indies
M.D degree February 1999

Quinnipiac University — **1993**
B.A Biology, *cum laude*
Hamden, CT

HONORS & AWARDS

Patient's Choice Award — **2010**
Internal Medicine

Most Compassionate Doctor — **2011**

Patients Choice Award — **2012**

America's Top Physician — **2007**

Who's who in Science and Engineering — **1998**
Who's who in America
Who's who in Healthcare

RESEARCH

Principal Investigator
A multicenter, randomized, double-blind study to evaluate the efficacy and safety of Alogliptin Compare to Glipizide in elderly subjects with type 2 diabetes — **2008-2011**

Sub-Investigator
Vildagliptin- A multi-center, randomized, open label, active controlled, parallel arm study to compare the efficacy of 12 weeks of treatment with Vildagliptin 100mg, qd to TZD's as add on therapy in patients with Type2 diabetes inadequately controlled with metformin monotherapy — **2006-2009**

Primary Investigator — **2006-2009**
Apidra 3515 all target Lantus with stepwise addition of Apidra vs Lantus with one injection of Apidra vs Novolog 70/30 mix in patients with type 2 diabetes failing dual or triple therapy: A 64 week multi-center open label clinical trial

Primary Investigator 2005-2007
Predictive 303 impact of a self-adjusted titration guideline in subjects with type 2 diabetes: A 6 month multi-center, randomized, open label, parallel group

Research Assistant 1997
Jacqueline Quinn, MD, St. Mary's Hospital department of surgery "HIV Testing, Why Patients Refuse" Analyzed response forms and correlated data for final analysis for publication.

Research Assistant 1997
Kenneth Kaluostian, PhD, Quinnipiac University, Department of Science
The Effects of Opioid Peptides on the Earthworm, *Lumbricus Terrestris*

EMPLOYEEMENT

Franklin Medical Group
Electronic Health Record Campion
Waterbury, CT 2009 – Present

Franklin Medical Group
Medical Director
Waterbury, CT 2011 – Present

Franklin Medical Group
Primary Care Partners
Prospect, CT 2008-Present

Greater Waterbury Primary Care Associates, P.C
Internal Medicine Private Practice
Prospect, CT 2002-2008

State of Connecticut, Department of Mental Retardation 1996-2002
Worked along with Down's McCune Albright Syndrome, and Tuberous Sclerosis people. Helped to teach them basic skills for supervised employment

Ross University School of Medicine 1993-1996
Assisted anatomy professors in teaching first semester students clinical anatomy

Campion Ambulance 1991-1993
Worked as an EMT with paramedics

State of Connecticut, Department of Emergency Medical Services 1990-1993
Worked along with certified EMS instructors to teach EMT students CPR, Trauma and other life saving techniques

PROFESSION ORGANIZATIONS

American College of Physicians Associate Member 1999- Present
American Medical Student Association Member 1996-1999

MILITARY

Connecticut Army National Guard 2015-Present
Rank Major- Staff Physician

CAREER EXPERIENCE

STS MGM, LLC – Cincinnati, Ohio-----August 2009 to present

- Waterbury,Ct-Nov 2015 to present-Franklin Med Grp (Saint Mary's Hosp)-Exec. Director
- Macon, Georgia- May to Nov 2015- Navicent Health Physicians Group – Sr. Consultant
- Columbus, Ohio - June 2014 to Mar 2015 – Mid Ohio Eye – Practice Administrator
- Columbus, Ohio – May 2014 to Mar 2015-Hand and Microsurgery–Practice Administrator
- Parkersburg, WV - October 2013 to May 2014 – Three Practices - Merger Consultant
- Columbus, Ohio - January 2012 to October 2013 – OrthoNeuro - Practice Administrator
- Cincinnati, Ohio - June 2011 to Nov. 2011 – Cardiology Associates - Executive Director
- Cincinnati, Ohio - August 2009 to May 2011 – Ohio Valley Ortho - Practice Administrator

Prexus Health – Hamilton, Ohio

July 2004 to August 2009 – Vice-President for Marketing & Development

Wellington Orthopaedic & **Sports Medicine —** Cincinnati, Ohio

January 1996 to September 2004 - Chief Operating Officer

Deaconess Health Care Services Company — Cincinnati, Ohio

April 1994 to December 1995 — Director, Primary Care Network Services

University of Cincinnati Medical Center — Cincinnati, Ohio

December 1992 to March 1994— Vice President, Practice Management Information Systems
September 1990 to January 1993 — Perinatal/Neonatal Product Line Manager
January 1989 to December 1992 — Senior Business Administrator

Wright State University, School of Medicine — Dayton, Ohio

July 1983 to January 1989 — Assistant Dean for Clinical Operations
October 1982 to January 1989 - Administrative Director, Medical Practice Plan Management

Rural Health Activities of Southeastern Indiana — Lawrenceburg, Indiana

June 1980 to October 1982 — Executive Director

ACADEMIC PREPARATION

1980: Master's Degree in Health Administration - Xavier University, Cincinnati, Ohio
1975: Bachelor's Degree in Natural Sciences - University of Cincinnati, Cincinnati, Ohio

CAREER PLANS AND FOCUS

I plan to work for five to seven more years providing "interim" or "turnaround" or "merger" practice management services via engagements that generally last for six to twenty-four months.

SKILLS

- Proven Ability to Organize and Lead Large Projects; Excellent Communication & Relationship Skills
- Proven Ability to Strengthen Governance, Operations, Information Technology Platform & Financial Performance
- Able to "Vision" and Successfully Execute Strategy to Achieve Vision
- Able to Assist Clinical Team and Entry Level Managers in Understanding/Managing Business

VOLUNTEER ACTIVITIES

- Bayley Continuing Care Retirement Community (board member till 12/31/15)
- Our Daily Bread Soup Kitchen (server)
- Ronald McDonald House (guest services)
- Hoxworth Blood Center (four seasons donor)

SCOPE AND ACCOMPLISHMENTS

STS MGM, LLC – Cincinnati, Ohio
August 2009 to present

I have provided "interim" management, "turnaround" management and "merger facilitation" to medical practices via a contract with my single-owner, limited liability company called "Short Term Senior Medical Group Management (STS MGM, LLC.)". My contracts have lasted for six to twenty four months and I attained my work via "word of mouth" referrals. I enjoy the challenge of providing direction and leadership to organizations in difficult situations.

Prexus Health – Hamilton, Ohio
July 2004 to August 2009 – Vice President for Marketing & Development

I facilitated and led the development of physician owned surgical centers, surgical hospitals and imaging centers. Projects included both new and fiscally troubled entities. The economic crisis of 2008 coupled with the implementation of the early stages of the Affordable Care Act made the continued development of physician owned ancillary businesses difficult for my physician owned employer.

Wellington Orthopaedic & Sports Medicine – Cincinnati, Ohio
January 1996 to September 2004 - Chief Operating Officer

As Chief Operating Officer for a 24 physician, musculoskeletal medical group, I reported directly to the physician owners of the organization. Wellington had three separate fiscal entities (i.e. a for-profit practice corporation, a limited liability corporation, and a not-for-profit foundation). My primary responsibilities included: development of strategy and execution of the related business plan; facilitation of the internal physician-led, governance process; recruitment of needed physician professionals; external relations with the business community and insurance leaders; ancillary revenue development; marketing; and oversight of daily operations. In 2004, Wellington delivered 90,000 office visits to patients annually and had combined revenues totaling $22 million. Wellington added physical therapy services in late 2003 and was expected to deliver 76,000 therapy visits and collect an additional $6 million in annual operating revenue in fiscal year 2005.

Deaconess Health Care Services Company – Cincinnati, Ohio
April 1994 to December 1995 – Director Network Services

As Chief Operating Officer for a 27 physician 12 office, hospital employed, primary care medical group, my responsibilities included: strategic and tactical planning; executing the group's business plan; management of patient accounts receivable; management of information systems; business systems development; and physician relations. I was recruited to accept my role at Wellington by a physician and trusted administrator.

University of Cincinnati Medical Center – Cincinnati, Ohio
February 1989 to March 1994 - several different titles

As the Vice-President for Information Systems for University of Cincinnati Medical Associates, I led a project to merge 15 separate departmental "billing systems" onto one common information system, while improving business operations. I accepted this position at the request of the President of University Hospital. As Senior Business Administrator for Obstetrics and Gynecology, I served as the Chief Operating Officer for the Department's two physician practice corporations (patient care), as well as the Chief Administrative Officer for the Department's University activity (teaching and research). I was asked to serve as Perinatal-Neonatal Product Line Manager in order to improve the hospital's service for mothers and babies. In this role, I was responsible for reducing the cost of hospital services, improving patient satisfaction and securing new business.

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 Farmington, Connecticut 06032-2330
Office Address	Saint Francis Hospital and Medical Center Department of Obstetrics and Gynecology 114 Woodland Street Hartford, Connecticut 06105
Telephone	Office: (860) 714-4457 Home: (860) 678-1218
Martial status	Marytherese Conway - October 2, 1987
Children	Alexandra - September 8, 1989 Katrina - May 7, 1992 Anna - May 22, 1995

Education

1972-1976	BA- Biology Cornell University Ithaca, New York
1976-1980	MD Autonomous University of Guadalajara Guadalajara, Mexico
1980-1981	Fifth Pathway St. Joseph's Hospital & Medical Center Paterson, New Jersey
1981-1985	Resident, Obstetrics and Gynecology St. Joseph's Hospital & Medical Center Paterson, New Jersey
1985-1987	Fellowship in Maternal-Fetal Medicine University of Connecticut Health Center Farmington, Connecticut

	1993-1996	Fellowship in Human Genetics Department of Pediatrics University of Connecticut Health Center Farmington, Connecticut
	2005	Six Sigma Green Belt Certification
	2007	American College of Physician Executives PIM Course
Licensure	New Jersey Connecticut New York	40792 26709 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 University of Connecticut Health Center Farmington, Connecticut
	1987-1993	Assistant Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
	1987-1995	Assistant Professor, Department of Pediatrics School of Medicine, University of Connecticut Health Center Farmington, Connecticut
	1987 - 2001	Attending Obstetrician and Gynecologist Specializing in Maternal-Fetal Medicine St. Francis Hospital & Medical Center Hartford, Connecticut

1987 - 2001	Associate Attending Obstetrician and Gynecologist Specializing in Maternal-Fetal Medicine New Britain General Hospital New Britain, Connecticut
1991-1993	Residency Coordinator Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
3/93 – 6/01	Residency Program Director Department of Obstetrics and Gynecology University of Connecticut Health Center Farmington, Connecticut
3/93 – 6/01	Associate Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
1995 – 6/01	Associate Professor, Department of Pediatrics University of Connecticut Health Center Farmington, Connecticut
1/99 – 6/01	Professor, Obstetrics and Gynecology Division of Maternal-Fetal Medicine Director of Perinatal Genetics University of Connecticut Health Center Farmington, Connecticut
7/01-3/04	Chairman, Obstetrics and Gynecology Stamford Hospital Stamford, Connecticut
9/01-5/13	Professor of Clinical Obstetrics and Gynecology Columbia University College of Physicians and Surgeons New York, New York
7/11-present	Chair, Department of Obstetrics and Gynecology Director, Women & Children's Health Services Saint Francis Hospital and Medical Center Hartford, Connecticut

2/13-Present	Saint Francis Faculty Fellow Saint Francis Hospital Education Council Hartford, Connecticut
5/13-present	Professor, Department of Obstetrics and Gynecology University of Connecticut Health Center 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)

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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

4. Rodis JF: Lyme disease in pregnancy. The Unicorn Perinatal Newsletter, 1991, Vol. 1, No. 1.

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Chapters

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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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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.

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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)

15. Leo MV, Odibo, AO, Ling, PY, Rodis JF, Borgida AF, Campbell WA; Transverse Arrest: a review of Outcomes of Rotational Forceps and Cesarean Delivery at a Single Center. ACOG National Clinical Meeting, New Orleans, LA, May 1998. (Poster presentation)

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)

18. Gottschall D, Borgida AF, Feldman D, Alberti W, Rodis JF: Preinduction cervical ripening comparing 50 and 100 mcg of misoprostol. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

19. Campbell WA, Feeney L, Fabbri EL, Iannucci P, Borgida AF, Rodis JF, Clive J: Assessment of amniotic fluid index using a curvilinear transducer: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

20. Campbell WA, Sanders M, Rosenkrantz T, Leo MV, Odibo AO, Ling PY, Rodis JF: A center's nine-year outcome experience with congenital diaphragmatic hernia. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7, 1998. (Poster presentation)

21. Odibo AO, Rodis JF, Sanders MM, Borgida AF, Wilson M , Campbell WA: Correlation of amniotic fluid markers of intraamniotic infection with histopathology in cases of preterm labor: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 - 7 1998. Poster presentation.

22. Odibo AO, Borgida AF, Egan JFX, Rodis JF, Sanders MM, Campbell WA: Relationship of amniotic fluid glucose with histopathologic chorioamnionitis in cases of preterm labor with intact membranes: Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 – 7, 1998 Poster presentation.

23. Odibo AO, Borgida AF, Rodis JF, Sanders MM, Leo MV, Campbell WA: The relationship of gestational age to histologic chorioamnionitis in preterm labor with intact membranes. Society of Perinatal Obstetricians Annual Meeting, Miami, Fla. Feb. 2 – 7, 1998 Poster presentation.

24. Rodis JF, Borgida AF, Wilson M, Egan JFX, Leo MV, Odibo AO, Campbell WA: Management of Parvovirus Infection in Pregnancy and Outcomes of Hydrops: A Survey of SPO Members. Society of Perinatal Obstetricians, Miami, FL, February 2-7, 1998 (Poster presentation)

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)

28. Gottschall D, Borgida AF, Mihalek JJ, Sauer F, Rodis JF. Misoprostol versus Prostin E2 gel for preinduction cervical ripening. Society of Perinatal Obstetricians, Anaheim, CA., January 1997. (Poster presentation)

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)

31. Rodis JF, Rinaldi LM, Cusick W, White C: Continuity clinics in obstetrics and gynecology residency programs: one institution's experience. 1996 CREOG and APGO Annual Meeting, Albuquerque, New Mexico, March 1996. (Poster presentation)

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)

33. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation of umbilical artery levels of interleukin-6 (IL-6) and soluble intracellular adhesion molecule-1 (SICAM-1) with umbilical arterial blood gas measurements. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

34. Smulian JC, Bhandari V, Campbell WA, Vintzileos AM, Rodis JF: Correlation of umbilical artery and vein levels of interleukin-6 and soluble intracellular adhesion molecule-1 with neonatal hematologic indices and early sepsis. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

35. Smulian JC, Campbell WA, Ernst L, Vintzileos AM, Rodis JF: The relation of umbilical vein interleukin-6 and soluble intracellular adhesion molecule-1 to histologic placental inflammation. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

36. Smulian JC, Campbell WA, Vintzileos AM, Rodis JF: Correlation between umbilical artery and umbilical vein levels of interleukin-6 and soluble intracellular adhesion molecule-1. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

37. Vintzileos AM, Campbell WA, Rodis JF, Guzman ER, Smulian JC, McLean DA: The use of second trimester genetic sonogram in guiding clinical management of patients at increased risk for fetal trisomy 21. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Oral presentation)

38. Vintzileos AM, Egan JFX, Smulian JC, Campbell WA, Guzman ER, Rodis JF: Adjusting the risk for Trisomy 21 by a simple ultrasound method using fetal long bone biometry. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

39. Campbell WA, Vintzileos AM, Smulian JC, Rodis JF, Guzman ER, Egan JFX: Ultrasound to detect trisomy 21 using transverse cerebellar diameter and long bone biometry. Society of Perinatal Obstetricians, Hawaii, February, 1996.

40. Rodis JF, Rodner C, Borgida AF, Spivey G, Shulman-Rosengren S, Campbell WA. Long-term outcome of children following maternal parvovirus infection. Society of Perinatal Obstetricians, Hawaii, February, 1996.

41. Borgida AF, Eng F, Egan JFX, Rodis JF, Smeltzer JS, Turner GW, Campbell WA: Umbilical cord gas assessment in high risk twin gestations. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

42. 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. Society of Perinatal Obstetricians, Hawaii, February, 1996. (Poster presentation)

43. Rodis JF, Sanders M, Ernst L, Fast A, Campbell WA: Placental pathology in preeclamptic pregnancies including decidual vascular pathology and villitis. Society of Gynecologic Investigation, Chicago, March, 1995.

44. Turner GW, Smeltzer JS, Rodis JF, Campbell WA: The value of amniotic fluid index in post term pregnancies. American Institute for Ultrasound in Medicine, San Francisco, March, 1995.

45. Rodis JF, Sanders M, Ernst L, Fast A, Borgida A, Campbell WA: Does placental pathology in preeclampsia correlate to maternal hypertension or neonatal birthweight percentile? New England Perinatal Society, Vermont, February, 1995. (Oral presentation)

46. Smulian JC, Feeney L, Fabbri EL, Rodis JF, Campbell WA: Second trimester sonographic prediction of fetal gender. Society of Perinatal Obstetricians, Atlanta, January, 1995.

47. Smulian JC, Campbell WA, Rodis JF, Feeney L, Fabbri EL: Gender specific second trimester biometry. Society of Perinatal Obstetricians, Atlanta, January, 1995.

48. Vintzileos AM, Campbell WA, Guzman E, Rodis JF, Rosenberg J: The use of "genetic sonogram" in fetuses at high risk for trisomy 21: Preliminary results. Society of Perinatal Obstetricians, Atlanta, January, 1995.

49. Rodis JF, Sanders M, Ernst L, Fast A, Borgida A, Campbell WA: Does placental pathology in preeclampsia correlate to maternal hypertension or neonatal birthweight percentile? Society of Perinatal Obstetricians, Atlanta, January, 1995. (Poster presentation)

50. Rodis JF, Sanders M, Ernst L, Fast A, Campbell WA: Placental pathology in preeclamptic pregnancies including decidual vascular pathology and villitis. Society of Perinatal Obstetricians, Atlanta, January, 1995.

51. Hardardottir H, Kelly K, Bork MD, Cusick W, Rodis JF, Campbell WA: Atypical presentation of preeclampsia in high-order multifetal gestation. Society of Perinatal Obstetricians, Atlanta, January, 1995.

52. Turner GW, Smeltzer JS, Rodis JF, Campbell WA: The value of amniotic fluid index in post term pregnancies. Society of Perinatal Obstetricians, Atlanta, January, 1995.

53. Borgida A, Rodis JF, Hanlon W, Craffey A, Ciarleglio L, Campbell WA: A prospective randomized trial comparing intramuscular 15 methyl-prostaglandin F2a to intravaginal prostaglandin E2 for second-trimester pregnancy termination. Society of Perinatal Obstetricians, Atlanta, January, 1995.

54. Rodis JF, Ciarleglio L, Egan JFX, Campbell WA, Vintzileos, AM: Women's intuition: Fact or fiction? 23rd Annual Meeting of American Society for Psychosomatic Obstetrics and Gynecology, Washington, DC, February, 1995. (Poster presentation)

55. Cusick W, Bork M, Chieffo V, Egan JFX, Smulian J, Rodis JF, Campbell WA, Vintzileos AM: The relationship between birthweight discordancy and amniotic fluid lecithin/ sphingomyelin in twin gestations. American College Obstetricians and Gynecologists, Orlando, May, 1994

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

57. Ciarleglio L, Cusick W, Briganti S, Feeney L, Benn P, Rodis JF: Pregnancy outcome in patients with a second trimester triple screen positive for trisomy eighteen. Society of Perinatal Obstetricians, Las Vegas, January 1994.

58. Cusick W, Salafia C, Rodis JF, Campbell WA, Vintzileos AM: Low dose aspirin therapy and placental pathology in women with prior poor pregnancy outcomes. Society of Perinatal Obstetricians, Las Vegas, January 1994.

59. Cusick W, Bork M, Chieffo V, Egan JFX, Smulian J, Rodis JF, Campbell WA, Vintzileos AM: The relationship between birthweight discordancy and amniotic fluid lecithin/ sphingomyelin in twin gestations. Society of Perinatal Obstetricians, Las Vegas, January 1994.

60. 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. Society of Perinatal Obstetricians, Las Vegas, January 1994.

61. Smulian J, Vintzileos AM, Ciarleglio L, Rodis JF, Campbell WA: Gender-specific patterns of long-bone measurements in fetuses with trisomy 21. Society of Perinatal Obstetricians, Las Vegas, January 1994.

62. Rodis JF, Egan JFX, Vintzileos AM, Campbell WA: Defining discordancy in fetal biometric parameters (BPD, HC, AC, FL) and estimated fetal weight in twins throughout gestation. Society of Perinatal Obstetricians, Las Vegas, January 1994.

63. Rodis JF, Egan JFX, Vintzileos AM, Campbell WA: Defining discordancy in fetal biometric parameters (BPD, HC, AC, FL) and estimated fetal weight in twins throughout gestation. Third World on Ultrasound in Obstetrics and Gynecology, Las Vegas, October, 1993.

64. Campbell WA, Yamase HA, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique Development. International Fetal Medicine and Surgery Society, April, 1993, (Oral presentation)

65. Vintzileos AM, Lettieri L, Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. American Institute of Ultrasound in Medicine, 37th Annual Convention, March, 1993.

66. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. New England Perinatal Society, February 1993. (Oral presentation-Ross Award for Best Clinical Oral Presentation and Abstract)

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)

68. Rodis JF, Lettieri L, McLean DA, Cusick W, Smulian J, Campbell WA, Vintzileos AM: A new method to correct the incarcerated retroflexed, retroverted gravid uterus. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

69. Campbell WA, Vintzileos AM, Rodis JF, Ciarleglio L, Craffey A: Ability of biparietal diameter/femur length ratio to detect down syndrome in patients with an abnormal biochemical screen. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

70. Gray SE, Rodis JF, Lettieri L, Egan JFX, Vintzileos AM: Effect of intravenous magnesium sulfate on the biophysical profile of the preterm fetus. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

71. Vintzileos AM, Lettieri L, Tsapanos V, Campbell WA, Rodis JF: The relationship between combined fetal biophysical activities, oligohydramnios and fetal acid-base status. Society of Perinatal Obstetricians, (SPO), San Francisco, February, 1993.

72. Cusick W, Vintzileos AM, Antsaklis A, Varvarigos I, Tassis S, Rodis JF: The use of oxytocin during labor and cord blood gas values. Society of Perinatal Obstetricians, San Francisco, February, 1993.

73. Cusick W, Vintzileos AM, Varvarigos I, Verikios N, Tassis S, Rodis JF: Mixed umbilical cord blood gas measurements. Society of Perinatal Obstetricians, San Francisco, February, 1993.

74. Cusick W, Vintzileos AM, Rodis JF, McMahon M: The use of second trimester fetal growth curves in predicting intrauterine growth retardation in cases of unexplained maternal serum alpha fetoprotein elevations. Society of Perinatal Obstetricians, San Francisco, February, 1993.

75. Mallozzi A, Egan JFX, Attar E, Feeney L, Ciarleglio L, Rodis JF, Lettieri L, Vintzileos AM: Down Syndrome risk modification based on ultrasound. Society of Perinatal Obstetricians, San Francisco, February, 1993.

76. Cusick W, Albini MA, Rodis JF, McLean DA, Vintzileos AM: Longitudinal assessment of fetal growth in cases of unexplained maternal serum alpha fetoprotein elevations. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Oral presentation)

77. Lettieri L, Vintzileos AM, McLean DA, Rodis JF, Campbell WA, Wolf EJ: Transcerebellar measurements in twin pregnancies and the effect of intrauterine growth retardation. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Presented - Poster session)

78. Lettieri L, Rodis JF, Egan JFX, Vintzileos AM, Feeney L, Dellaripa P: Ear length in second trimester aneuploid fetuses. American Institute of Ultrasound in Medicine, 36th Annual Convention, San Diego, March, 1992. (Oral presentation)

79. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Mead J, Gray S: Does the pregnancy complication resulting in preterm delivery influence predischarge survival and morbidity? New England Perinatal Society, February, 1992. (Presented-Oral session)

80. Albini SM, Cusick W, Rodis JF, Lettieri L, McMahon M, Vintzileos AM: Routine amniocentesis is not indicated to evaluate an unexplained elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

81. Cusick W, Rodis JF, Vintzileos AM, Albini SM, McMahon M, Campbell WA: Pregnancy outcome by the degree of maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

82. Cusick W, Albini MA, Rodis JF, McLean DA, Vintzileos AM: Longitudinal assessment of fetal growth in cases of unexplained elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

83. Egan JFX, Vintzileos AM, Turner GT, Rodis JF, Campbell WA, Wolf EJ, Balducci J, Lettieri L, Mead J: Correlation of uterine fundal height with ultrasound in twin gestations. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

84. Rodis JF, Wolf EJ, Lettieri L, Scribner D, Campbell WA, Vintzileos AM: Management and outcome of severe preeclampsia in 209 preterm pregnancies. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992

85. Rodis JF, Vintzileos AM, Albini M, Nardi DA, Feeney L, Lettieri L, Wolf EJ, Ciarleglio L: Transverse cerebellar diameter measurements in second trimester fetuses with trisomy 21 and trisomy 18. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

86. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Mead J, Gray S: Does the pregnancy complications resulting in preterm delivery influence predischarge survival and morbidity? Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

87. Wolf EJ, Vintzileos AM, Rosenkrantz T, Rodis JF, Lettieri L, Mallozzi A: A comparison of predischarge survival and morbidity in singleton and twin very low birthweight infants. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

88. Campbell WA, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, Nardi DA: Use of the transverse cerebellar/abdominal circumference ratio to identify growth retarded fetuses. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

89. Campbell WA, Yamase HT, Salafia CM, Vintzileos AM, Rodis JF: Fetal renal biopsy: Technique development. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

90. Campbell WA, Vintzileos AM, Rodis JF, Nochimson DJ: Birthweight outcome in pregnancies complicated by an elevated maternal serum alpha fetoprotein. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992.

91. Turner GW, Vintzileos AM, Nardi DA, Feeney L, Campbell WA, Rodis JF: Neck circumference measurements in second trimester fetuses with Down syndrome. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

92. Lettieri L, Vintzileos AM, Rodis JF, Campbell WA: Transcerebellar measurements in twin pregnancies and the effect of intrauterine growth retardation. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session)

93. Lettieri L, Rodis JF, Egan JFX, Vintzileos AM, Feeney L, Dellaripa P: Ear length in second trimester aneuploid fetuses. Society of Perinatal Obstetricians, (SPO), Orlando, February, 1992. (Presented - Poster session

94. Wolf EJ, Egan JFX, Rodis JF, Vintzileos AM, Miller R: Intravenous adenosine for the treatment of maternal paroxysmal supraventricular tachycardia. Armed Forces District, American College of Obstetricians and Gynecologists and Organization for Obstetric, Gynecologic and Neonatal Nurses. Cincinnati, Ohio, October 6-10, 1991.

95. Vintzileos AM, Fleming AD, Scorza WE, Wolf EJ, Balducci J, Campbell WA, Rodis JF: Relationship between fetal biophysical activities and umbilical cord blood gases. Society for Gynecologic Investigation, San Antonio, March, 1991.

96. Egan JFX, Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Fleming AD, Scorza WE: Umbilical cord blood pH discordancy and its relation to fetal acidemia. New England Perinatal Society, Vermont, February, 1991.

97. Campbell WA, Cusick W, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, McLean DA: Outcome of quadruplet pregnancies using early hospitalization. New England Perinatal Society, Vermont, February, 1991.

98. Rodis JF, Vintzileos AM, Fleming AD, Ciarleglio L, Nardi DA, Feeney L, Scorza WE, Campbell WA, Ingardia C: Comparison of humerus length versus femur length in fetuses with Down syndrome. New England Perinatal Society, Vermont, February, 1991.

99. Wolf EJ, Mallozzi A, Rodis JF, Egan JFX, Vintzileos AM, Campbell WA, Lettieri L: Placenta previa is not an independent risk factor for IUGR. New England Perinatal Society, Vermont, February, 1991.

100. Wolf EJ, Mallozzi A, Rodis JF, Campbell WA, Mead JA, Vintzileos AM: A 10-year review of preterm births of twins at a referral tertiary care center. New England Perinatal Society, Vermont, February, 1991.

101. Wolf EJ, Mallozzi A, Rodis JF, Campbell WA, Vintzileos AM: A 10-year review of preterm births a referral tertiary care center. New England Perinatal Society, Vermont, February, 1991.

102. . Wolf EJ, Mallozzi, Rodis JF, Egan JFX, Vintzileos AM, Campbell WA, Lettieri L: Placenta previa is not an independent risk factor for IUGR. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

103. Wolf EJ, Mallozzi A, Rodis JF, Campbell WA, Mead JA, Vintzileos AM: A 10-year review of preterm birth of twins at a referral tertiary care center. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

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105. Campbell WA, Cusick W, Vintzileos AM, Rodis JF, Turner GW, Egan JFX, McLean DA: Outcome of quadruplet pregnancies using early hospitalization. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

106. Balducci J, Rodis JF, Rosengren S, Vintzileos AM, Davis G, Vosseller C: Neonatal outcome after first trimester varicella infection. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

107. Fleming AD, Salafia CM, Vintzileos AM, Rodis JF, Campbell WA, Bathan KF: The relationships among umbilical artery velocimetry, fetal biophysical profile and placental inflammation in preterm PROM. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

108. Egan JFX, Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Fleming AD, Scorza WE: Umbilical cord blood pH discordancy and its relation to fetal acidemia. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

109. Scorza WE, Nardi DA, Vintzileos AM, Fleming AD, Rodis JF, Campbell WA: The relationship between umbilical artery Doppler velocimetry and fetal biometry. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

110. Vintzileos AM, Egan JFX, Rodis JF, Campbell WA, Wolf EJ, Balducci J: Clinical characteristics and significance of nuchal cord. Society of Perinatal Obstetricians, (SPO), San Francisco, January, 1991.

111. Fleming AD, Rodis JF, Vintzileos AM, Ingardia C, Scorza WE, Ciarleglio L, Craffey A, Feeney L, Nardi D: Comparison of humerus length versus femur length in fetuses with Trisomy 21 and Trisomy 18. Society of Perinatal Obstetricians (SPO), San Francisco, January, 1991.

112. Vintzileos AM, Egan JFX, Campbell WA, Rodis JF, Scorza WE, Fleming AD, McLean DA: Asphyxia at birth as determined by cord blood pH measurements and correlation with neonatal outcomes. New England Perinatal Society, Vermont, February, 1990.

113. Vintzileos AM, Campbell WA, Rodis JF, McLean DA, Egan JFX, Fleming AD, Scorza WE: The relationship between fetal biophysical assessment, umbilical artery velocimetry and fetal acidosis in patients undergoing cesarean section prior to the onset of labor. New England Perinatal Society, Vermont, February, 1990.

114. Fleming DA, Salafia C, Vintzileos AM, Rodis JF, Campbell WA, Bantham KF: The relationships among umbilical arterial velocimetry, fetal biophysical profile and placental inflammation in preterm premature rupture of the membranes. New England Perinatal Society, Vermont, February, 1990.

115. Rodis JF, Ciarleglio L, Petrikovsky BM, Egan JFX, Campbell WA, Vintzileos AM: Women's intuition: fact or fiction? Society of Perinatal Obstetricians (SPO), Houston, January, 1990.

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David M. Bittner, CPA, MBA, FHFMA

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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.

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:

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 12

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

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

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Kimberly R. Martone
Office of health Care Access
November 12, 2015

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,

Paul Kelly, MD
Chief of Cardiology

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.

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56 Franklin Street, Waterbury, CT 06706

Saint Mary's
HOSPITAL

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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

56 Franklin Street, Waterbury, CT 06706

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

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Kimberly R. Martone
Office of Health Care Access
November 11, 2015

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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

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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Sincerely,

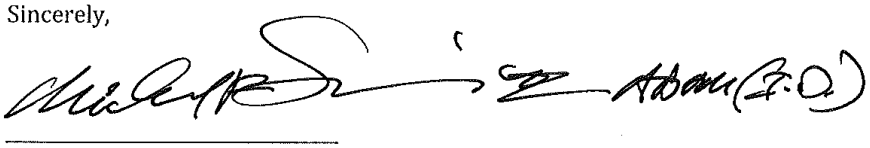

EXHIBIT 13

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 sector-wide 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

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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

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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

EXHIBIT 14 a

COMMENTARY

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.

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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

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 16

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 17

FOR-PROFIT

Franklin Medical Group, P.C.
Financial Worksheet (B)

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY15**	**FY16**	**FY**	**FY16**	**FY17**	**FY**	**FY17**	**FY18**	**FY**	**FY18**	**FY19**	**FY**	**FY19**
		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	$64,215	$82,743	$0	$82,743	$86,880		$86,880	$91,224		$91,224	$95,785		$95,785
2	Less: Allowances	$36,599	$47,515	$0	$47,515	$50,413		$50,413	$53,489		$53,489	$56,751		$56,751
3	Less: Charity Care	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$27,616**	**$35,228**	**$0**	**$35,228**	**$36,467**	**$0**	**$36,467**	**$37,736**	**$0**	**$37,736**	**$39,034**	**$0**	**$39,034**
5	Medicare	$7,501	$9,568	$0	$9,568	$9,904		$9,904	$10,249		$10,249	$10,602		$10,602
6	Medicaid	$5,670	$7,232	$0	$7,232	$7,487		$7,487	$7,747		$7,747	$8,014		$8,014
7	CHAMPUS & TriCare	$55	$70	$0	$70	$73		$73	$75		$75	$78		$78
8	Other	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
	Total Government	**$13,225**	**$16,871**	**$0**	**$16,871**	**$17,464**	**$0**	**$17,464**	**$18,072**	**$0**	**$18,072**	**$18,693**	**$0**	**$18,693**
9	Commercial Insurers	$13,896	$17,727	$0	$17,727	$18,350		$18,350	$18,989		$18,989	$19,642		$19,642
10	Uninsured	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$196	$250	$0	$250	$259		$259	$268		$268	$277		$277
12	Workers Compensation	$229	$292	$0	$292	$303		$303	$313		$313	$324		$324
13	Other	$69	$88	$0	$88	$91		$91	$94		$94	$98		$98
	Total Non-Government	**$14,391**	**$18,357**	**$0**	**$18,357**	**$19,003**	**$0**	**$19,003**	**$19,664**	**$0**	**$19,664**	**$20,341**	**$0**	**$20,341**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$27,616**	**$35,228**	**$0**	**$35,228**	**$36,467**	**$0**	**$36,467**	**$37,736**	**$0**	**$37,736**	**$39,034**	**$0**	**$39,034**
14	Less: Provision for Bad Debts	$1,495	$1,477	$0	**$1,477**	$1,551		**$1,551**	$1,628		**$1,628**	$1,710		**$1,710**
	Net Patient Service Revenue less provision for bad debts	**$26,121**	**$33,751**	**$0**	**$33,751**	**$34,916**	**$0**	**$34,916**	**$36,107**	**$0**	**$36,107**	**$37,324**	**$0**	**$37,324**
15	Other Operating Revenue	$4,162	$3,725	$0	**$3,725**	$3,800		**$3,800**	$3,800		**$3,800**	$3,800		**$3,800**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$30,283**	**$37,476**	**$0**	**$37,476**	**$38,716**	**$0**	**$38,716**	**$39,907**	**$0**	**$39,907**	**$41,124**	**$0**	**$41,124**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$32,716	$38,677	$0	$38,677	$39,644		$39,644	$40,635		$40,635	$41,651		$41,651
2	Fringe Benefits	$4,371	$4,794	$0	$4,794	$4,914		$4,914	$5,037		$5,037	$5,163		$5,163
3	Physicians Fees	$1,022	$949	$0	$949	$977		$977	$1,007		$1,007	$1,037		$1,037
4	Supplies and Drugs	$1,567	$1,586	$0	$1,586	$1,587		$1,587	$1,666		$1,666	$1,750		$1,750
5	Depreciation and Amortization	$306	$295	$0	$295	$304		$304	$313		$313	$322		$322
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$816	$1,274	$0	$1,274	$1,299		$1,299	$1,325		$1,325	$1,352		$1,352
9	Lease Expense	$2,046	$2,318	$0	$2,318	$2,364		$2,364	$2,412		$2,412	$2,460		$2,460
10	Other Operating Expenses	$4,252	$4,779	$0	$4,779	$4,875		$4,875	$4,972		$4,972	$5,072		$5,072
	TOTAL OPERATING EXPENSES	**$47,096**	**$54,672**	**$0**	**$0**	**$55,965**	**$0**	**$55,965**	**$57,367**	**$0**	**$57,367**	**$58,806**	**$0**	**$58,806**
	INCOME/(LOSS) FROM OPERATIONS	**($16,813)**	**($17,196)**	**$0**	**$37,476**	**($17,249)**	**$0**	**($17,249)**	**($17,460)**	**$0**	**($17,460)**	**($17,682)**	**$0**	**($17,682)**
	NON-OPERATING INCOME	**($8)**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**($16,821)**	**($17,196)**	**$0**	**$37,476**	**($17,249)**	**$0**	**($17,249)**	**($17,460)**	**$0**	**($17,460)**	**($17,682)**	**$0**	**($17,682)**

FOR-PROFIT

Franklin Medical Group, P.C.

Financial Worksheet (B)

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY15**	**FY16**	**FY**	**FY16**	**FY17**	**FY**	**FY17**	**FY18**	**FY**	**FY18**	**FY19**	**FY**	**FY19**
		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**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**
	NET INCOME	**($16,821)**	**($17,196)**	**$0**	**($17,196)**	**($17,249)**	**$0**	**($17,249)**	**($17,460)**	**$0**	**($17,460)**	**($17,682)**	**$0**	**($17,682)**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**-55.5%**	**-45.9%**	**0.0%**	**100.0%**	**-44.6%**	**0.0%**	**-44.6%**	**-43.8%**	**0.0%**	**-43.8%**	**-43.0%**	**0.0%**	**-43.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-55.6%**	**-45.9%**	**0.0%**	**-45.9%**	**-44.6%**	**0.0%**	**-44.6%**	**-43.8%**	**0.0%**	**-43.8%**	**-43.0%**	**0.0%**	**-43.0%**
E.	**FTEs**	**0**	**0**	**0**	**0**			**0**			**0**			**0**
F.	**VOLUME STATISTICS[d]**													
1	wRVUs	398,786	488,339	0	**488,339**	512,756		**512,756**	538,394		**538,394**	565,313		**565,313**
2	Total Visits	330,811	343,041	0	**343,041**	360,193		**360,193**	378,203		**378,203**	397,113		**397,113**
	TOTAL VOLUME	**729,597**	**831,380**	**0**	**831,380**	**872,949**	**0**	**872,949**	**916,596**	**0**	**916,596**	**962,426**	**0**	**962,426**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT 18

Financial Assistance Policy

Effective Date: 10/1/2014

Revised:

Replaces: 9/1/2012

It is the policy of the Practice that patients experiencing financial hardship may apply for a discount or waiver of the patient's financial responsibility (e.g., full payment if self-insured or non-covered services). Whether such a discount or waiver is granted shall be based on an individual assessment of the patient's financial circumstances, and an assessment of the Practice's legal and contractual obligations to the third-party payers.

SELF-PAY

A Self-Pay patient is one who is financially responsible, either personally or as a guarantor, for the payment of charges associated with the health care services provided by Franklin Medical Group (FMG)

POLICY

1. All fully responsible self-pay accounts will be eligible for a **20% discount** off of the published charges, regardless of their income or assets.
2. Insured patients with balances that were denied by their insurance as "non-covered service" are eligible to apply for financial assistance on those balances (with exception of elective-cosmetic procedures)
3. Patient co-pays, deductibles and coinsurance balances after insurance are **not** eligible for a discount

UNINSURED

An uninsured patient is one:

- Whose income is at or below 425% of the Federal Poverty Income levels;
- Who does not have insurance coverage under any State or Federal program or with any private carrier

POLICY

1. The Practice does not advertise its financial hardship discount program, nor does it routinely offer discounts or waivers to patients.
2. In order to be considered for a discretionary discount or waiver, the patient must be uninsured and individualized documentation of financial hardship must be submitted and reviewed. The documentation needed to apply for a financial hardship discount or waiver is listed below:
    a. A completed Patient Financial Assessment Form (see attached).
    b. One or more of the following:

1) Documented proof that a patient is at or below 425% percent of the current federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. Documented proof may include documents such as W-2 withholding statements, unemployment check stubs, paycheck stubs, income tax return (1040), forms from Medicaid or other state-funded medical assistance, forms from employers, and/or welfare or community agencies.
2) Documentation that a patient has other circumstances that indicate financial hardship, which may include, but not be limited to, proof of bankruptcy settlement, catastrophic situations (e.g., death or disability in family), or another documentation that shows that the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses. The Administrator or designee is responsible for considering the grant or denial of hardship status under these circumstances on a case-by-case basis. Documentation must be submitted for the review.

5. Any denial of the financial hardship discount or waiver request is documented and includes instructions for reconsideration. If additional documentation is received to support the financial hardship, the request is reviewed and considered per the above guidelines. The decision of the Administrator or designee is final.

6. All information relating to financial hardship requests is kept confidential, except as required by law.

7. Elective-cosmetic procedures are **not** eligible for financial assistance

8. Patients seeking financial assistance, who are under sponsorship (Immigration and Naturalization Services) of relatives are required to provide income and asset verifications of the sponsor, in order to determine eligibility. Undocumented immigrants who cannot produce income verifications will follow the regular Self-Pay collection process.

9. Financial counseling is specific to an individual's situation and exceptions to the policy may occur. These will be authorized and approved by the President of Franklin Medical Group.

PROCESS

1. Applications can be obtained from the Financial Counselor or the Office Front Desk Representative

2. A patient may request assistance at any time in the billing and collection process.

3. Completed and signed applications must be returned to the Financial Counselor within **14 days** with required verifiable documentation or the collection hold will be removed; incomplete or falsified applications will not be considered.

4. After the completed application is received, all related accounts will be changed to the Financial Assistance Financial Class and collection activity will be put on hold while the eligibility status is determined

5. The Financial Counselor assesses patient for state assistance eligibility and may obtain information from the Hospital's financial counselors to aid in determining whether a patient qualifies for medical assistance from other sources or is pending approval. All third-party resources and non-Medical Group financial aid,

including Medicaid, must be exhausted before assistance can be granted. Failure to cooperate or refusing to apply for Medicaid will disqualify the patient/guarantor from obtaining financial assistance.

6. FMG will utilize the Income and Asset Worksheet (attached) in conjunction with the most recent Federal Poverty Income Levels as a basis for the determination of eligibility. The applicant's gross *Household* income will be used in determining eligibility for assistance.

7. If a patient is defined as uninsured, the balance of all accounts will be reduced given the sliding scale discount based upon information provided in the application.

8. To assure that discounts are appropriately considered, the following approval levels will be followed:

   a. $1 - $1,000 Controller
   b. $1,001 and up President

9. Patients found eligible for assistance will be eligible for any balance due at the time of the application and any non-elective services received within the next one-hundred and eighty (180) days after the date the application was filed. FMG reserves the right to require a new application for any new service received.

10. FMG Financial Counselor will document all decision regarding the discounts awarded by signing and dated the application, documenting in the notes of the patient's record, and documentation will be maintained for seven years.

11. If, after all discounts are approved, a patient due balance remains, the account(s) will be moved back to Self Pay Financial Class and the Self Pay collection process will continue.

Policy Approved By:

_____

Controller

PATIENT FINANCIAL ASSISTANCE APPLICATION

Date: _____ Account #: _____

Social Security #: _____

Patient last name: _____ First name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Alternate phone #: _____

Name of responsible party (if not patient, print name of Guarantor): _____

Patient's employer: _____ Employer phone #: _____

Employer address: _____ City: _____ State: ____ ZIP: _____

Length of employment: _____ If unemployed, last date of employment: _____

Spouse last name: _____ First name: _____

Spouse employer: _____ Employer phone #: _____

Employer address: _____ City: _____ State: ____ ZIP: _____

Length of employment: _____ If unemployed, last date of employment: _____

Total in household (include yourself): Adults (18+) _____ Minors (under 18) _____

Guarantor (responsible party) employer: _____ Phone #: _____

Employer address: _____ City: _____ State: ____ ZIP: _____

Length of employment: _____ If unemployed, last date of employment: _____

Income (monthly)	**Patient**	**Spouse**	**Responsible Party**	**Children Working**
Gross Monthly Salary	$	$	$	$
Public Assistance Benefits	$	$	$	$
Unemployment Benefits	$	$	$	$
Social Security Benefits	$	$	$	$
Workers' Compensation	$	$	$	$
Child Support	$	$	$	$
Other (Alimony, Pension, Life Insurance, VA Benefits, Disability	$	$	$	$
TOTALS:	$	$	$	$

*Total household income: $*_____

Other assistance: _____

Have you applied for Medicaid: Yes No (circle)

If "yes," provide current status or attach denial letter: _____

Have you tried to obtain financial assistance from other organizations? Yes No (circle)

List the organizations and current status:

_____

_____

Please provide any additional information/comments:

(Attach additional sheet if more space is required, or use the back of this form.)

_____

_____

Financial Documentation: (attach copies)

Previous year 1040 IRS: $_____ Year _____

W-2s: $_____ Year _____

If patient claims income is less than the previous calendar year tax form; attach most recent four pay stubs.

$ _____ Date _____ $ _____ Date _____

$ _____ Date _____ $ _____ Date _____

Other (unemployment, Social Security, disability and workers' compensation): (attach copies)

$ _____

$ _____

	Monthly Pmt		**Balance**	**Monthly Payment**
Mortgage/rent	$	VISA	$_____	$_____
Gas & electric		MC	$_____	$_____
Telephone		AMEX	$_____	$_____
Car Insurance		Discover	$_____	$_____
Food			**Total Monthly Credit Card Expense:**	$_____
Other				
TOTAL	$			

Yearly Household Income		
Gross:	$	
Net:	$	

** I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to Franklin Medical Group is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges.*

** By signing and submitting this request, I give Franklin Medical Group permission to determine my need for financial assistance, including review of my credit file..*

** I understand that it is my responsibility to advise Franklin Medical Group of any changes in status in regards to my income or assets while this application is in process.*

Signature of patient: _____ Date:_____

Signature of spouse or guarantor: _____ Date:_____

Return this form and supporting documentation within 14 days to the Practice where you received services or mail to Financial Counselor, Franklin Medical Group, 56 Franklin Street, Waterbury, CT 06706. If you have questions, you may call 203-709-7022.

FMG INCOME AND ASSETS GUIDELINE WORKSHEET

Patient Name		**Total charges**	$ -
Patient ID Number(s)			
Admit Date		Insurance Paid	-
Date of application		Gurantor Paid	-
Requested by		Welfare Paid	-
Bill date			
		Balance	$ -
# of Family Members (select)		Disallowed	-
		Balance Eligible for Assistance	-
		Discount percentage approved	**0%**
Total Household Gross Income	**$ -**	**Amt of discount recommended**	-

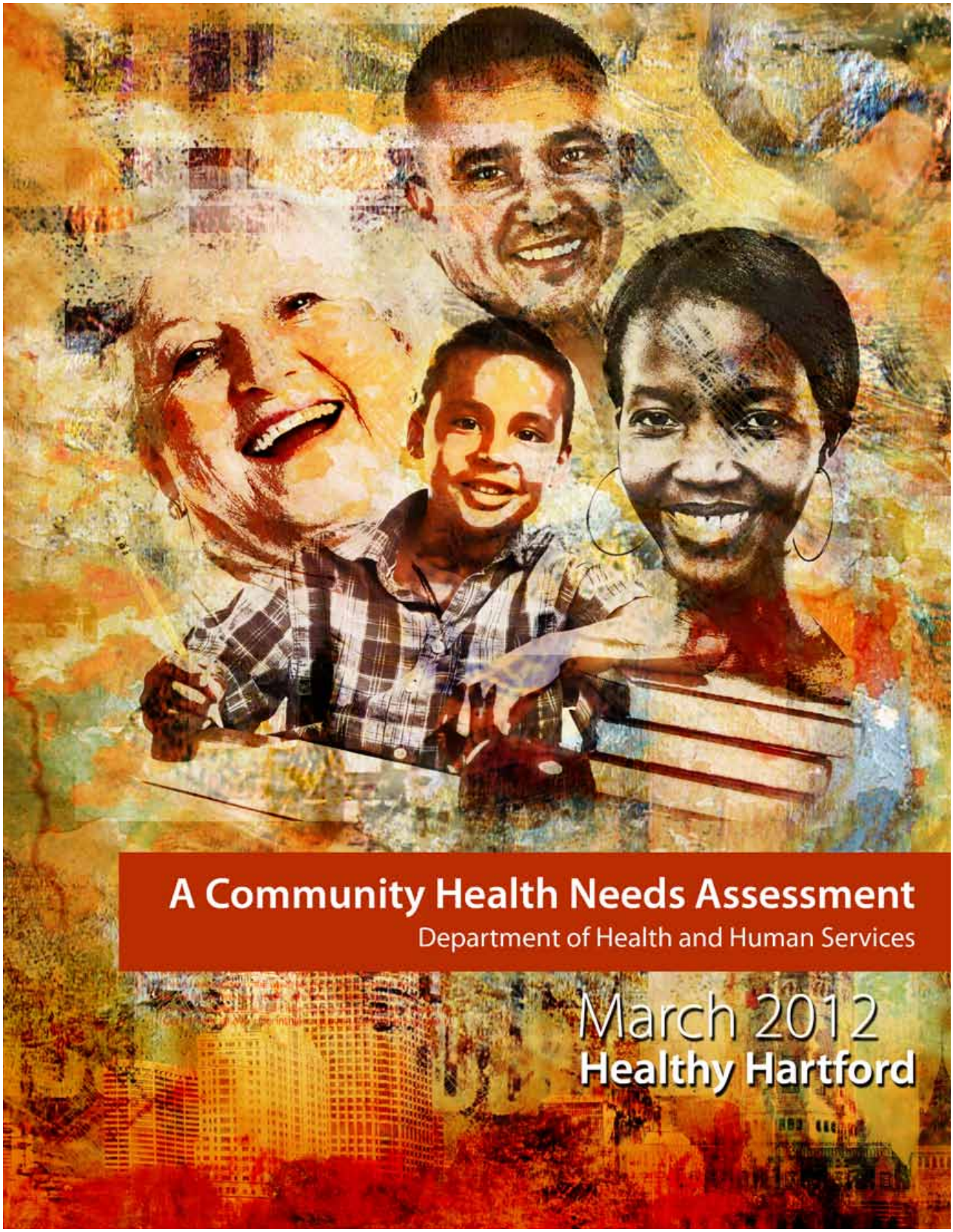
Income			**Liquid Assets**	
Total Monthly Household Gross Income	-		Savings/Checking account	-
Total Monthly Household Expenses Allowed	-	See below	Certificates of deposit	-
Monthly Applied Income	**$ -**		Stocks/bonds	-
			Other	-
Allowable Assets (= 6 months of Applied Income)	-		**Total**	**$ -**
Total amount disallowed	**$ -**			

2014 Federal Poverty Guidelines & Sliding Scale Discount

Persons in family / household	Poverty guideline	250%	275%	300%	325%	350%	375%	400%	425%
1	$11,670	$29,175	$32,093	$35,010	$37,928	$40,845	$43,763	$46,680	$49,598
2	15,730	39,325	43,258	47,190	51,123	55,055	58,988	62,920	66,853
3	19,790	49,475	54,423	59,370	64,318	69,265	74,213	79,160	84,108
4	23,850	59,625	65,588	71,550	77,513	83,475	89,438	95,400	101,363
5	27,910	69,775	76,753	83,730	90,708	97,685	104,663	111,640	118,618
6	31,970	79,925	87,918	95,910	103,903	111,895	119,888	127,880	135,873
7	36,030	90,075	99,083	108,090	117,098	126,105	135,113	144,120	153,128
8	40,090	100,225	110,248	120,270	130,293	140,315	150,338	160,360	170,383
For families/households with more than 8 persons, add $3,960 for each additional person.									
FPL Range	**< 250%**	**250-274%**	**275-299%**	**300-324%**	**325-349%**	**350-374%**	**375-399%**	**400 - 424%**	**425% +**
Discount %	**100%**	**90%**	**80%**	**70%**	**60%**	**50%**	**40%**	**30%**	**20%**
Example discount	$ -	$ 14.32	$ 28.64	$ 42.96	$ 57.27	$ 71.59	$ 85.91	$ 100.23	$ 114.55

		2014 Mcare	**FMG Charge**
Example:	Level 3 Office Visit	$ 81.82	$ 143.19

EXHIBIT 19


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.

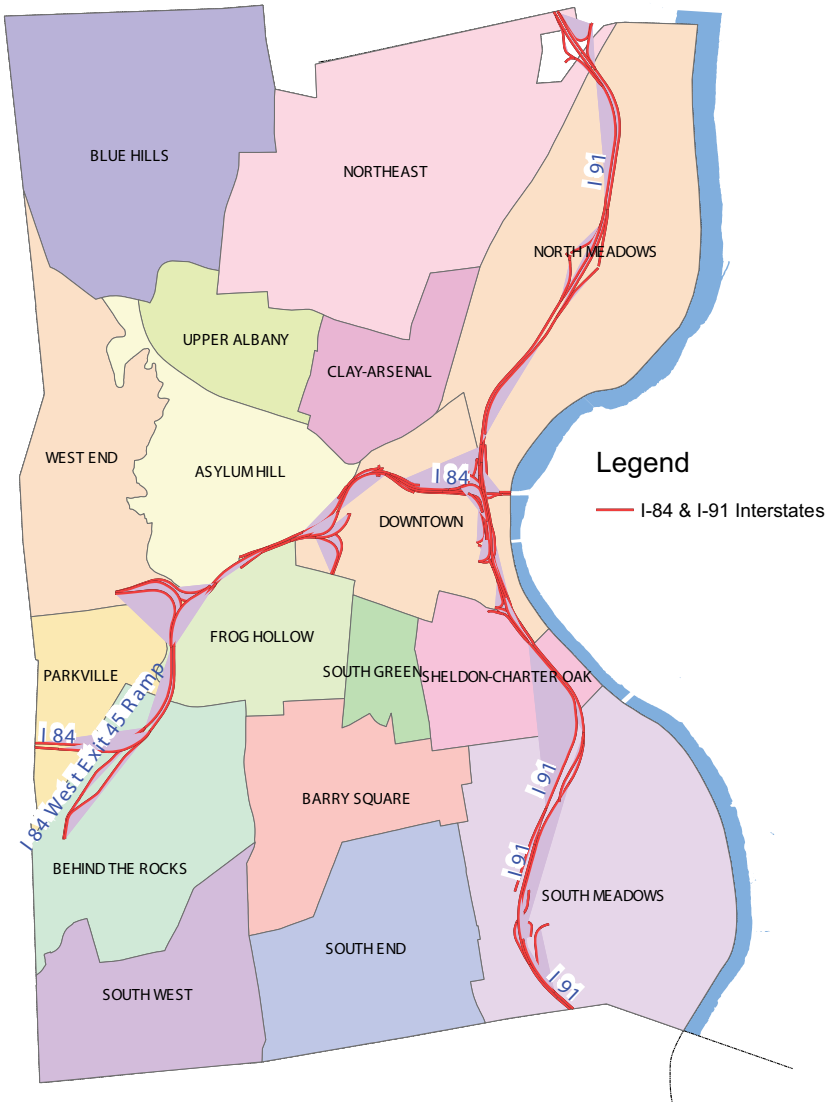
HEI maps were used to compare neighborhoods by social determinant or health outcome indicators. This comparison includes both the North Meadows and South Meadows neighborhoods for analysis, although the former is mainly comprised of car dealerships and landfill, and the latter with a small airport, a 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.**

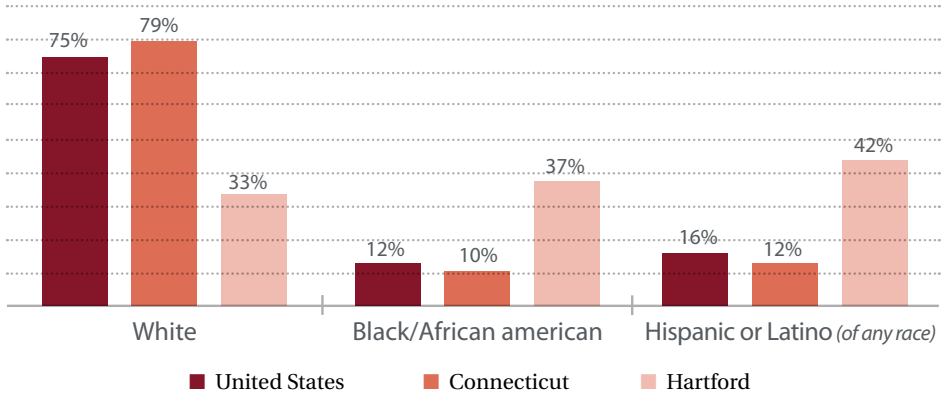
	HARTFORD	CT	US
0-19 years	**34%**	26%	27%
20-44 years	**37%**	32%	34%
45-64 years	**20%**	28%	26%
65 and older	**10%**	14%	13%

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.

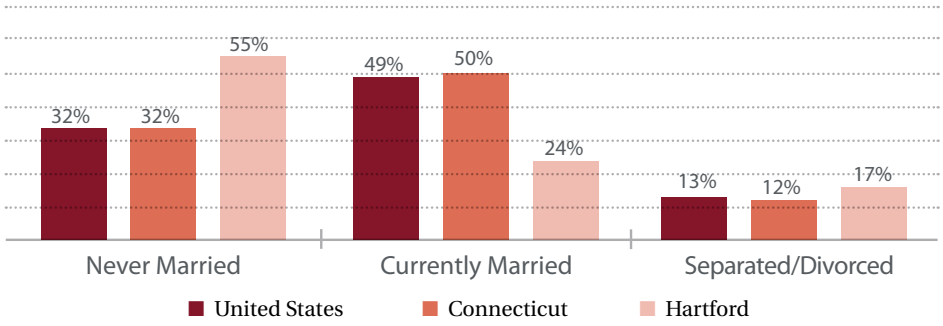
Figure 1. **Ethnic Composition for Hartford, Connecticut, and the U.S. (2009)**



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.

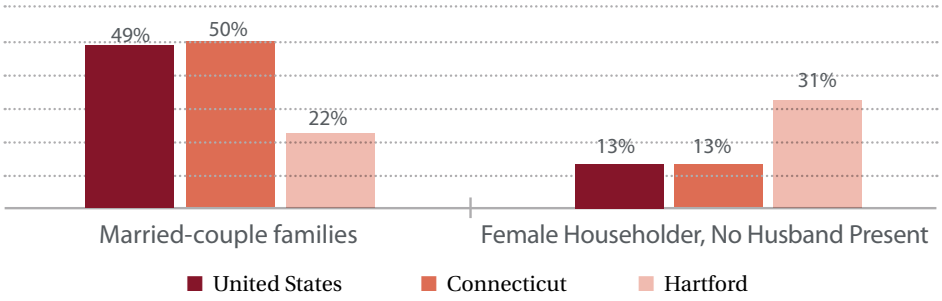
Subsidized housing is abundant in Hartford. As is typical throughout the United States, these subsidized housing units have become a feature of low-income and resource-poor areas. In Hartford, residing in subsidized housing is correlated with numerous health outcomes, such as increased rates of chlamydia 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***

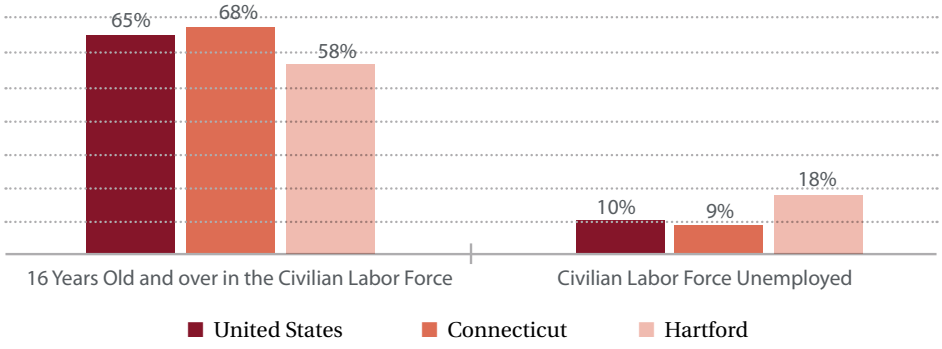
	HEI INDEX	CORRELATION COEFFICIENT
Infectious Disease	2	0.55
Health Care Access	2	0.47
Childhood Illness	1	0.42
Accidents/Violence	3	0.40
Mental Health	2	0.37
Renal Disease	2	0.33
Life Expectancy	3	0.31
Cardiovascular	3	0.29
Respiratory Illness	4	0.29
Diabetes	3	0.24
Perinatal Care	3	0.22
Liver Disease	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.

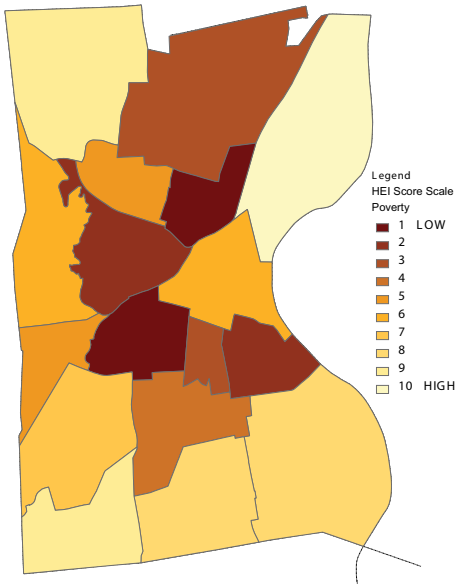
The lack of employment has long been linked to increased rates of mortality. For Connecticut, unemployment has been strongly correlated with decreased health care access, which can serve as a partial explanation for the correlations with a decreased life expectancy, and increased incidences of respiratory 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].

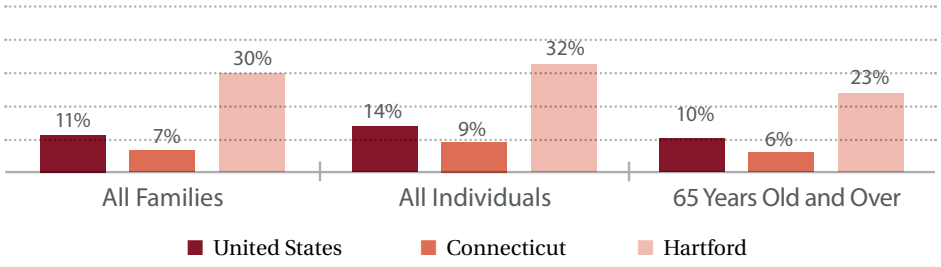
Below is a representation of how Hartford neighborhoods compare to each other with regard to poverty using HEI indexing from the 2000 U.S. Census. Using the color gradient in the legend, the darker colors indicate a lower ranking and higher level of poverty.

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

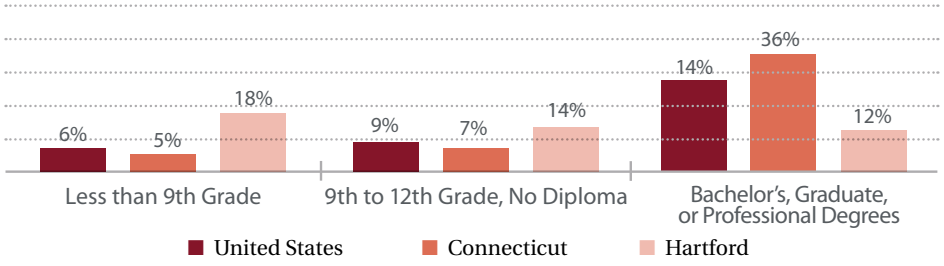
Note: All shown correlations are statistically significant and ranked in order from strong to weak.

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)**

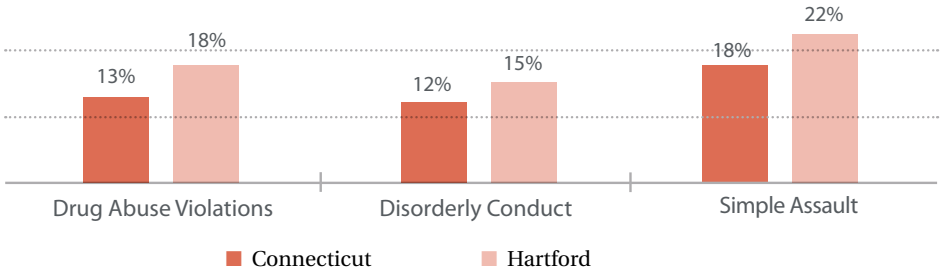


Community Safety

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

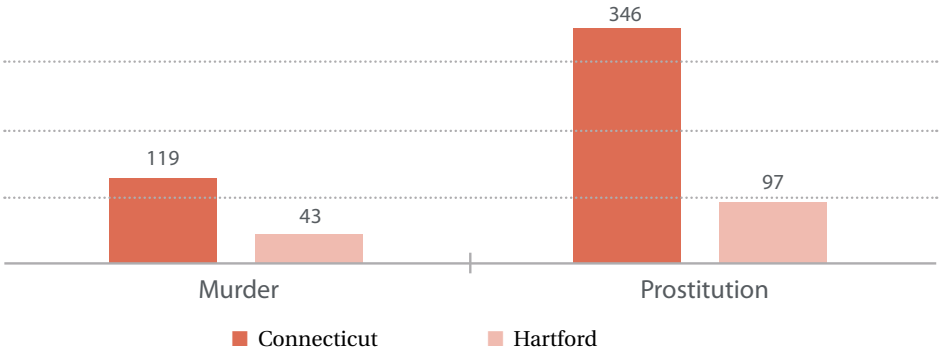
rate of arrests in the city could either indicate that crimes are more prevalent or that more effective law enforcement approaches have been implemented. Nevertheless, according to the 2009 Uniform Crime Report from the Connecticut Department of Public Safety, over one third of all murder arrests in 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)**

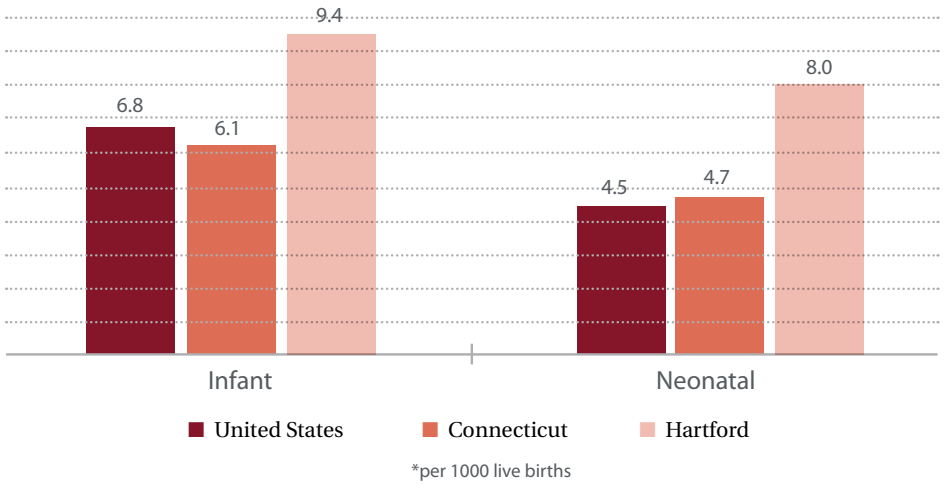
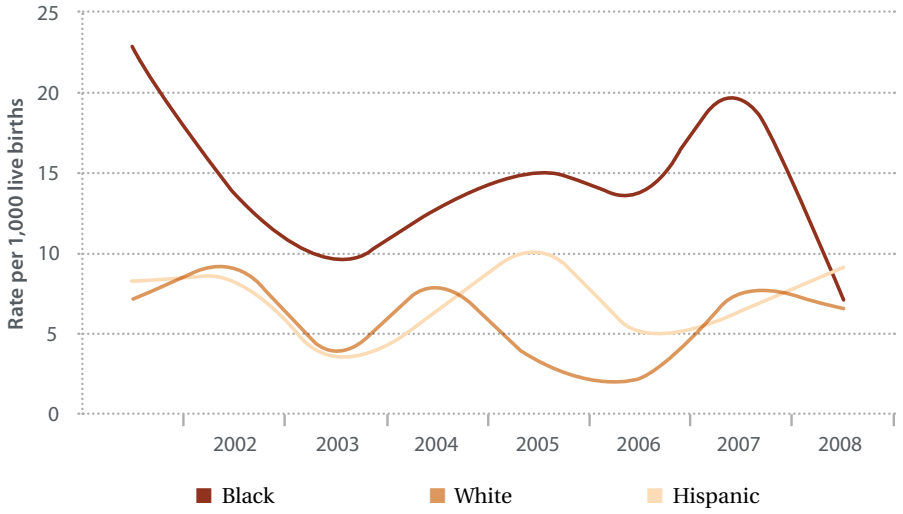
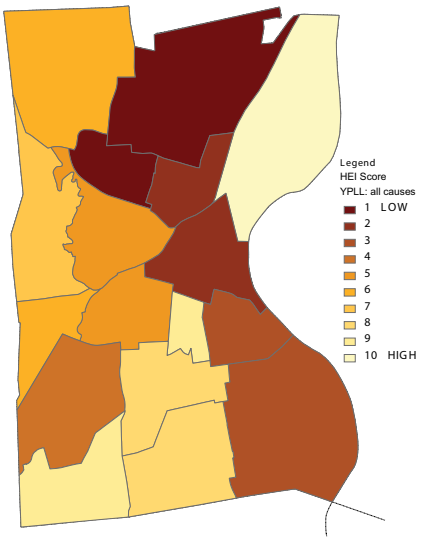


Figure 10. **Infant Mortality Rates by Race/Ethnicity, Hartford, CT (2001-2008)**



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***

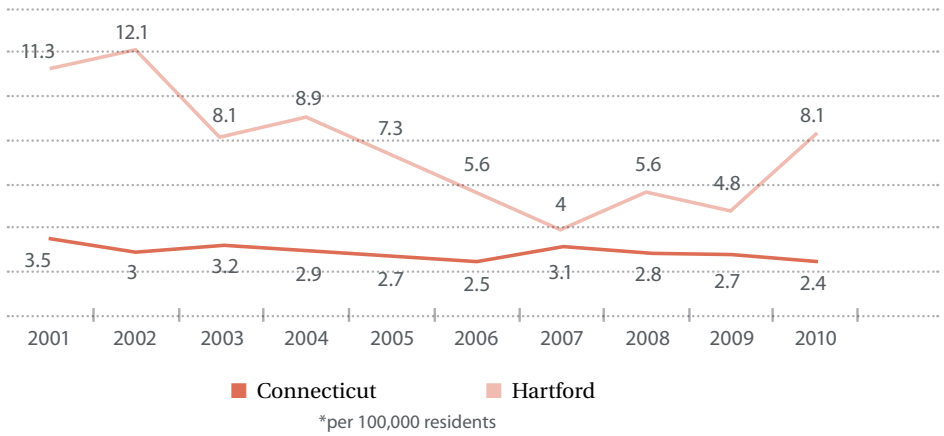
	INDEX SCORE	CORRELATION COEFFICIENT
Community Safety	1	0.67
Education	2	0.59
Environmental Quality	4	0.59
Civic Involvement	1	0.59
Economic Security	2	0.58
Housing	3	0.55
Employment	3	0.28

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.

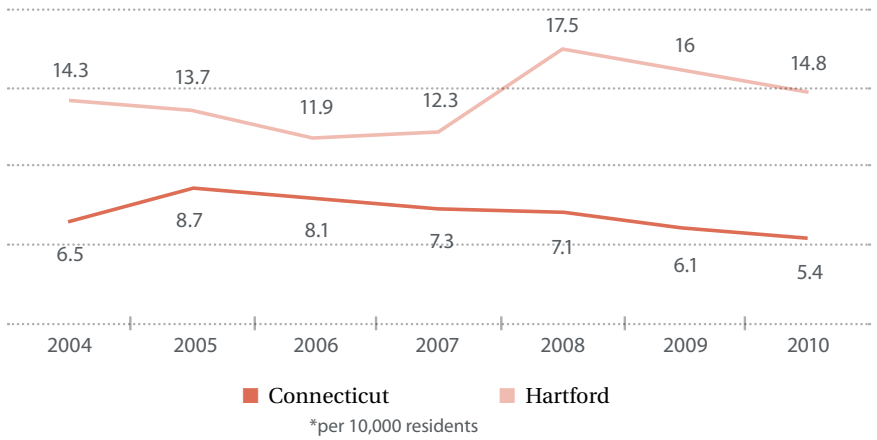
Table 11. **Syphilis in Hartford among Males by Age Category (2007-2010)**

	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.

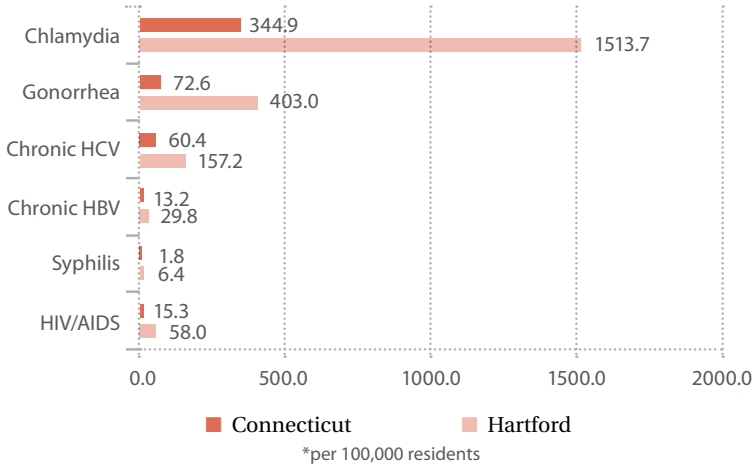
The information concerning **Hepatitis C** (HCV) for the state and the city is limited. From the data available, chronic HCV rates in Hartford have been declining for the past 3 years, yet they still remain 2.7 times greater than the state prevalence.

Figure 12. **Chronic HCV Prevalence* in Hartford and Connecticut (2004-2010)**



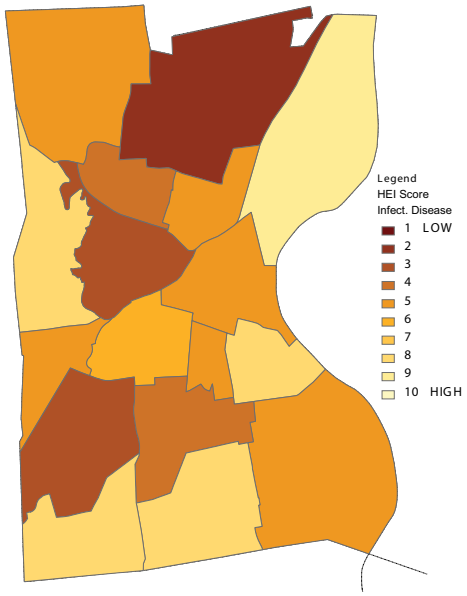
With these disproportionate rates of infection, it is not surprising that when compared to the state the city's HEI rating is 2 for all infectious diseases. The following displays a summary of how the city rates when looking at some of the infectious disease trends:

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**



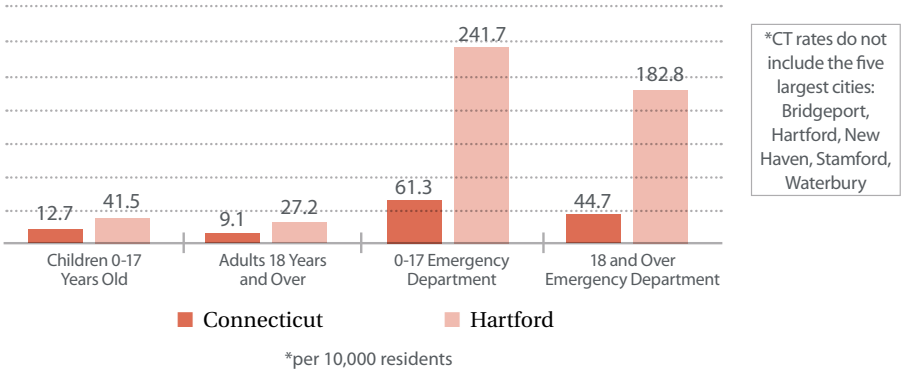
Based on secondary data analysis, Hartford has considerably higher rates of preventable infectious/communicable diseases than the state with the exception of Lyme disease.

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

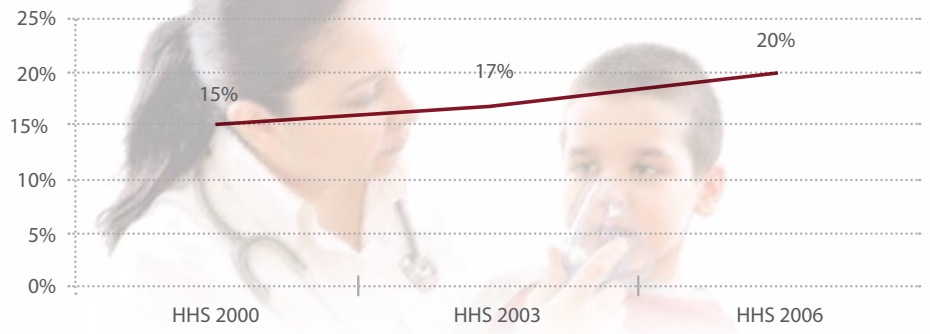
Based on data gathered in the Secondary Data Profile, asthma is an area of concern for the community. According to the Connecticut Department of Health, the hospitalization rates for asthma are notably higher for Hartford when compared to the state as seen in the following figure.

Figure 14. **Asthma Hospitalization Rates* in Hartford and Connecticut (2009)**



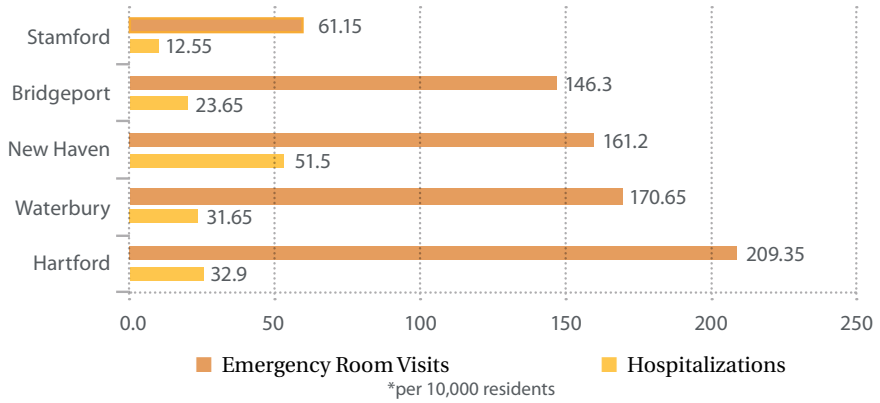
In 2006, the self-reported responses of current asthma among adults were 20%. This is the highest percentage of self-reported asthma in the past three Hartford Health Surveys, an HHS survey conducted through community partners every three years to gauge resident health and access to health care.

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.

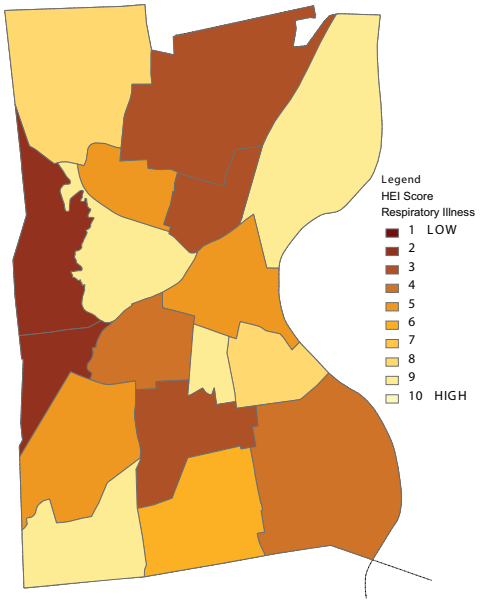
Table 12. **Social Determinants of Health Related to *Respiratory Illness***

	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**

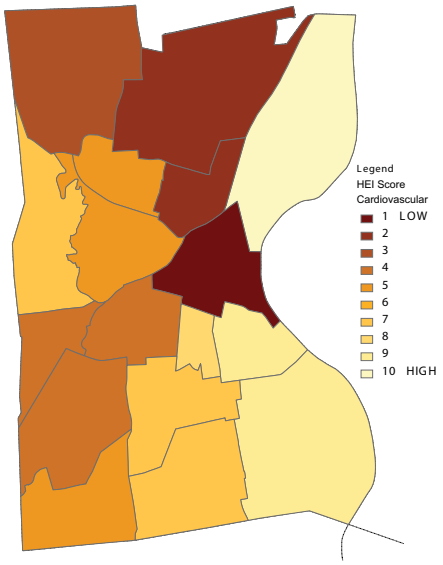
	HEALTHY WEIGHT	OVERWEIGHT	OBESE
1988-1994	41.9%	33.0%	22.7%
2001-2004	32.4%	34.7%	31.2%
2005-2008	30.9%	33.5%	33.9%

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.

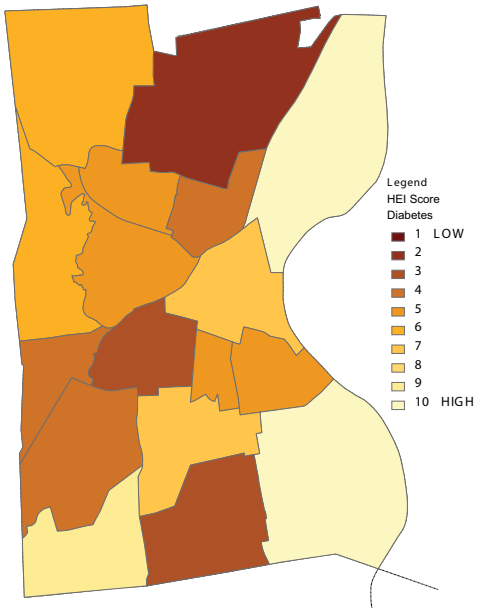
While Hartford's diabetes rate is lower than the state's, the CDC indicates that Hartford's rate is on the rise. If the state trend in diabetes is any indication of how the city is afflicted by this disease, then the assumption would be that the Black population is disproportionately affected when compared 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**

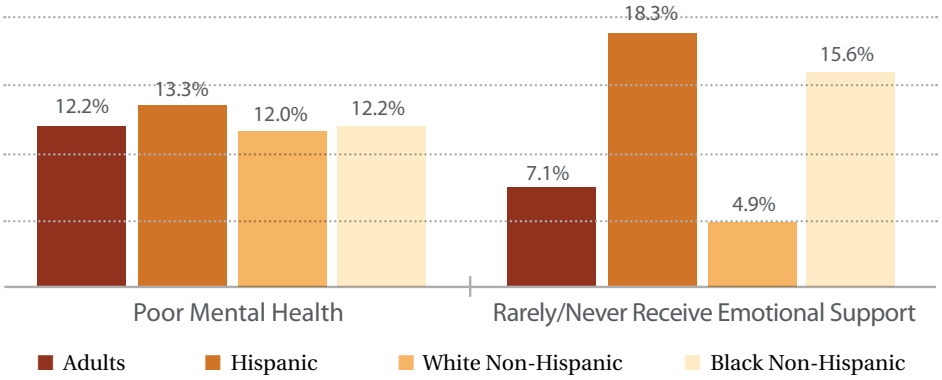


Behavioral Health

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.

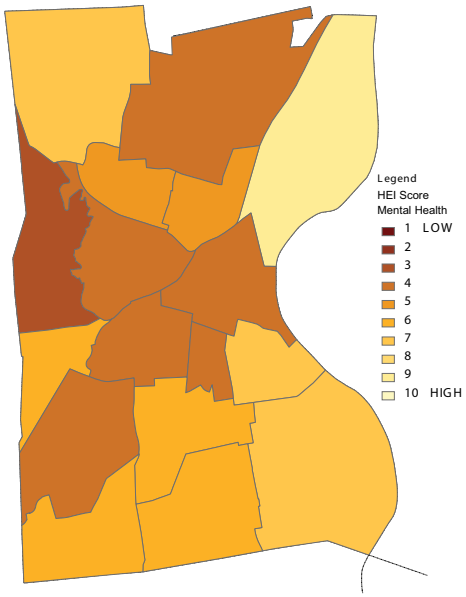
The behavioral health infrastructure is headed by the state through the Department of Mental Health and Addiction Services and its various partners; the complexity of mental health services designed to cater to large geographic regions encompassing the city as well as 37 other municipalities calls for 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 difícil 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 difícil 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 difícil 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 difícil 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. clínica 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.

PLAY
Healthy Hartford
WALK
Healthy Hartford
RUN
Healthy Hartford
BIKE
Healthy Hartford
Know
Your Numbers
HDL
Cholesterol
Healthy Hartford
Know
Your Numbers
L
H
Blood
Pressure
Healthy Hartford
Know
Your Numbers
Blood
Sugar
Healthy Hartford
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 20

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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2 Consolidating Statement of Operations for the year ended September 30, 2014	35

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

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 21

Provider Name/Facility Name	Service	Street	Town	State	Zip Code	Hours/Days of Operation	FY 14 Utilization (if available)
Bindu Dey	Internal Medicine	127 Pine Bridge Rd	Beacon Falls	CT	06403		
Sudipta Dey	Internal Medicine	127 Pine Bridge Rd	Beacon Falls	CT	06403		
Richard Wilber, MD	Pediatric Medicine	100 Nob Hill Rd	Cheshire	CT	06410		
Jeannette Chinchilla, MD	Pediatric Medicine	677 S Main St	Cheshire	CT	06410		
Eileen O'Reagan, MD	Geriatric Medicine	1781 Highland Ave Ste 106	Cheshire	CT	06410		
Maria Stack, MD	Geriatric Medicine	680 S Main St Ste 205	Cheshire	CT	06410		
Ashley Hendrix, DO	Geriatric Medicine	335 Highland Ave Ste 101	Cheshire	CT	06410		
Kasia Koziol-Dube, MD	Pediatric Medicine	288 Highland Ave Ste 6	Cheshire	CT	06410		
Erlinda Rauch, MD	Geriatric Medicine	25 Lewis Rd	Cheshire	CT	06410		
Daren Anderson, MD	Internal Medicine	20 Orleton Ct	Cheshire	CT	06410		
Erin Cardon, Md	Internal Medicine	1781 Highland Ave Ste 106	Cheshire	CT	06410		
Moon Lee, MD	Internal Medicine	759 S Main St	Cheshire	CT	06410		
Camille Bedrosian, MD	Internal Medicine	352 Knotter Dr.	Cheshire	CT	06410		
Leonard Bell, MD	Internal Medicine	352 Knotter Dr.	Cheshire	CT	06410		
Oluremi Aliyu, MD	Internal Medicine	25 Chesterwood Ct	Cheshire	CT	06410		
Sanela Tarabar, MD	Internal Medicine	1200 Bethany Mountain Rd	Cheshire	CT	06410		
Michael Collins, MD	Internal Medicine	892 Wolf Hill Rd	Cheshire	CT	06410		
Jdavid Gaines, MD	Internal Medicine	677 S Main St	Cheshire	CT	06410		
Eric Shaban, MD	Internal Medicine	85 Nob Hill Rd	Cheshire	CT	06410		
Kathryn Reavey, MD	Internal Medicine	556 Busk Ct	Cheshire	CT	06410		
Maud Ward, MD	Internal Medicine	366 S Main St Ste 2	Cheshire	CT	06410		
Michael J Ackley	Podiatric Surgeon	714 South Main Street	Cheshire	CT	06410	3:00P T & Th 9A - 12P First two	
Luis Alonso	Pediatric Medicine	288 Highland Ave Ste 2	Cheshire	CT	06410		
Karalyn Kinsella	Pediatric Medicine	435 Highland Ave Ste 110	Cheshire	CT	06410		
Kerline Vassell	Pediatric Medicine	288 Highland Ave Ste 6	Cheshire	CT	06410		
Sarah Balfour	Family Medicine	335 Highland Ave Ste 101	Cheshire	CT	06410		
Louis Dimauro	Pediatric Medicine	435 Highland Ave Ste 110	Cheshire	CT	06410		
Marie-Helene Pouliot	Pediatric Medicine	288 Highland Ave Ste 6	Cheshire	CT	06410		
Vivian Tsuei	Pediatric Medicine	288 Highland Ave Ste 6	Cheshire	CT	06410		
Elizabeth Herz, MD	Pediatric Medicine	435 Highland Ave Ste 110	Cheshire	CT	06410		
Brian Libler, MD	Pediatric Medicine	435 Highland Ave Ste 110	Cheshire	CT	06410		
Richard Williams, MD	Family Medicine	335 Highland Ave Ste 101	Cheshire	CT	06410		
Ellen Fischbein, MD	Pediatric Medicine	355 Highland Ave Ste 101	Cheshire	CT	06410		
Janet A. Pappianni-Paret, MD	Pediatric Medicine	100 Highland Ave	Cheshire	CT	06410		
Carol O'Dea, MD	Pediatric Medicine	10 Main St	Cheshire	CT	06410		
Michael Olsen, MD	Family Medicine	335 Highland Ave Ste 101	Cheshire	CT	06410		

James O'Connor Jr., MD	Pediatric Medicine	435 Highland Ave Ste 110	Cheshire	CT	06410		
Craig Keanna, MD	Pediatric Medicine	288 Highland Ave Ste 6	Cheshire	CT	06410		
Michael Willett, MD	Family Medicine	1157 Highland Ave	Cheshire	CT	06410		
James Sarfeh, MD	Internal Medicine	422 Highland Ave Ste 3	Cheshire	CT	06410		
Roman Khodzinsky, MD	Internal Medicine	1157 Highland Ave	Cheshire	CT	06410		
David Stair, MD	Inernal Medicine	677 S Main St	Cheshire	CT	06410		
Shilpa Shetty, MD	Internal Medicine	1274 Summit Rd	Cheshire	CT	06410		
David Silver, MD	Internal Medicine	28 S Main St	Cheshire	CT	06410		
Kevin Baruzzi, MD	Internal Medicine	246 Mountain Rd	Cheshire	CT	06410		
Elodie Nofiele, MD	Internal Medicine	223 Lancaster Way	Cheshire	CT	06410		
Benish Hussain, MD	Internal Medicine	1781 Highland Ave Ste 106	Cheshire	CT	06410		
Dennis Pilarczyk, MD	Internal Medicine	131 Cornwall Ave	Cheshire	CT	06410		
Eric Holmboe, MD	Internal Medicine	553 Busk Ct	Cheshire	CT	06410		
Husam Shitia, MD	Internal Medicine	430 Highland Ave	Cheshire	CT	06410		
Naugatuck Valley Cardiovascular Associates	Cardiology	1625 Straits Tpke Ste 209	Middlebury	CT	06762	M-F: 8:30A-4:30P	
S M. Albini	OBGYN	687 Straits TPKE STE 2A	Middlebury	CT	06762		
Edgar Catala	Internal Medicine	415 Middlebury Rd	Middlebury	CT	06762		
Leslie Coopersmith	Internal Medicine	415 Middlebury Rd	Middlebury	CT	06762		
Franco Galasso	Internal Medicine	415 Middlebury Rd	Middlebury	CT	06762		
Fausto M Lanao	Internal Medicine	415 Middlebury Rd	Middlebury	CT	06762		
Ralph V Tremaglio	Internal Medicine	415 Middlebury Rd	Middlebury	CT	06762		
Michael Damon Savarese	Internal Medicine	10 N Benson Rd	Middlebury	CT	06762		
Farah Choudhry	Pediatric Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
Jenny Hwang, MD	Pediatric Medicine	1625 Straits Tpke Ste 202	Middlebury	CT	06762		
Maurice Falk, MD	Pediatric Medicine	121 Tyler Xing	Middlebury	CT	06762		
Stephen Maddox, MD	Pediatric Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06702		
Linda Mathew, MD	Pediatric Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
Kweku G. Sam Jr., MD	Pediatric Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
Ira Mickenberg, MD	Geriatric Medicine	312 Three Mile Hill Rd	Middlebury	CT	06762		
Joseph Demayo, MD	Geriatric Medicine	66 Skyline Dr	Middlebury	CT	06762		
Robert Shepherd Sr., DO	Family Medicine	126 Falcon Crest Rd	Middlebury	CT	06762		
Ofelia Tee, MD	Pediatric Medicine	5 Dogwood Ct	Middlebury	CT	06762		
Michael Harma, MD	Internal Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
Jonathan Parkhurst, MD	Internal Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
Peter Levinson, MD	Internal Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
Joycelyn Maw, MD	Internal Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
David M. Corvini, MD	Internal Medicine	1652 Straits Tpke	Middlebury	CT	06762		
O Bizzozero Jr., MD	Internal Medicine	51 Curtis Rd	Middlebury	CT	06762		
Julien Naylor, MD	Internal Medicine	195 Chesham Dr.	Middlebury	CT	06762		
Ezzat Hafez, MB BCH	Pediatric Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		
Matthew Velsmid, MD	Internal Medicine	1625 Straits Tpke Ste 302	Middlebury	CT	06762		

Michael Savarese, MD	Internal Medicine	10 N Benson Rd	Middlebury	CT	06762		
Waterbury Hospital Blood Draw	Lab Draw Station	1625 Straits Turnpike #302	Middlebury	CT	06762		
Quest Diagnostics	Lab Draw Station	687 Straits Turnpike	Middlebury	CT	06762		
J Michael Elser	Internal Medicine	305 Church St Suite 15	Naugatuck	CT	06770		
Nader Habib, MD	Family Medicine	305 Church St Ste 6	Naugatuck	CT	06770		
Victor Vega, MD	Pediatric Medicine	577 N Church St	Naugatuck	CT	06770		
Carl Schiano, DO	Family Medicine	59 Rubber Ave	Naugatuck	CT	06770		
Adriana Ghisa, MD	Internal Medicine	305 Church St Ste 15	Naugatuck	CT	06770		
John Elser, MD	Internal Medicine	305 Church St Ste 15	Naugatuck	CT	06770		
Tracey Wiles, MD	Urgent Care Medicine	1177 New Haven Rd	Naugatuck	CT	06770		
Kenneth Newton, MD	Internal Medicine	305 Church St Ste 15	Naugatuck	CT	06770		
Dennis L Huebner	Internal Medicine	305 Church St	Naugatuck	CT	06770		
Gerald G Fette	Gastroenterology	1183 New Haven Rd Suite 202	Naugatuck	CT	06770		
Nahida S. Khan	Internal Medicine	131 Bridge St	Naugatuck	CT	06770		
Oscar Ransome	Pediatric Medicine	577 N Church St	Naugatuck	CT	06770		
Florentine Thomas	Pediatric Medicine	577 N Church St	Naugatuck	CT	06770		
Rocco Cornacchia, MD	Family Medicine	567 Field St	Naugatuck	CT	06770		
Dennis Huebner, MD	Internal Medicine	305 Church St Ste 1	Naugatuck	CT	06770		
Primary Care of Naugatuck	Primary Care	131 Bridge St	Naugatuck	CT	06770	4P W: 9A-5P F: 7:30A- 3:30P	
Alpa Patel, MD	Pediatric Medicine	710 Main St	Plantsville	CT	06479		
Alkesh V. Patel, MD	Internal Medicine	710 Main St Bldg 1	Plantsville	CT	06479		
Drew J Edwards	Family Practice	115 Waterbury Rd	Prospect	CT	06712		
Renika N Mcleod-Labissiere	Family Practice	115 Waterbury Rd	Prospect	CT	06712		
Donald Sampson	Internal Medicine	115 Waterbury Rd	Prospect	CT	06712		
Katrina Knapp, DO	Pediatric Medicine	22 Holley Ln	Prospect	CT	06712		
Quest Diagnostics	Lab Draw Station	166 Waterbury Rd	Prospect	CT	06712		
Prospect Family Medicine	Family Medicine	115 Waterbury Rd	Prospect	CT	06712		
Imran Al Khalil	Internal Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Lucia C Benzoni	Pediatric Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
AAQIB H Malik	Internal Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Ben Hur H Aguilar	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Adriana P Blanco	Rheumatology	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Christopher ERB	Internal Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Geetha Gangu	Internal Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Nora O Segar	Internal Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Arshwinder S Sohi	Internal Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Donna M Windish	Internal Medicine	611 E Hill Rd (Watermark at East Hill)	Southbury	CT	06488		
Fernado Afonso	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Alka Aggarwal	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Mohamed Y Ahmed	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		

Muhammad K Al Mounayer	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Gustavo D Alday	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Geethanjali Bandla	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
David Barendberg	Gastroenterology	22 Old Waterbury Rd	Southbury	CT	06488		
David Bass	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Asma Beg	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Mohammad F Belal	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Paul M Bellofiore	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Manisha Bhutani	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Mary E Blackman	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Damanjeet Chaubey	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Jay V D Orso	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
David Dayya	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Bidur Dhakal	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Mary Lee H Dilling	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Arthur G Dsouza	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Jeanine Famiglietti	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Cynthia Rachel Feher	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Yvette M Fernandez	Gaeriatric Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Jolanta S Fragoso	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Joseph Franceschina	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Jonathan M Gordon	Internal Medicine	22 Old Waterbury Rd	Southbury	CT	06488		
Adam Gorelic	Gastroenterology	23 Old Waterbury Rd	Southbury	CT	06488		
Priyanka Gupta	Internal Medicine	24 Old Waterbury Rd	Southbury	CT	06488		
Kariyawasam B Buddhini Gurusinghe	Internal Medicine	25 Old Waterbury Rd	Southbury	CT	06488		
Harvey Kramer	Cardiology	22 Old Waterbury Rd	Southbury	CT	06488	M-F 8A-4:30P	
Beth Sieling	Oncologist/Hematologist	33 Bullet Hill Rd	Southbury	CT	06488		
Sohel M. Islam	Cometic Surgeon/Plastic Surgeon	22 Old Waterbury Rd	Southbury	CT	06488		
Ellen Polokoff	Oncologist/Hematologist	900 Main St S #101	Southbury	CT	06488		
Madeleine Kitaj	Neurology	30 Quaker Farms Rd #2	Southbury	CT	06488		
Marianne Bette	Family Doctor	77 Main St N #107	Southbury	CT	06488		
Elise M. Romanik	Internist/Geriatrician	22 Old Waterbury Rd	Southbury	CT	06488		
Theresa Tartarone	Internist/Geriatrician	22 Old Waterbury Rd	Southbury	CT	06488		
Michael C. Trager	Internist/Geriatrician	385 Main St S #301	Southbury	CT	06488		
Robert Carr	Family Doctor/G.P.	22 Old Waterbury Rd #108	Southbury	CT	06488		
Richard N Biondi	Internist/Geriatrician	1 Pomperaug Office Park Ste 202	Southbury	CT	06488		
Jane Hunter	Internist/Geriatrician	385 Main St S Ste 106	Southbury	CT	06488		
Susan Beris	Pediatric Medicine	22 Old Waterbury Rd #204	Southbury	CT	06488		

Casey Ott	Internist/Geriatrician	22 Old Waterbury Rd #103	Southbury	CT	06488		
William Filchak	Optometrist	775 Main St S	Southbury	CT	06488		
Rose Yu-Chin	Psychiatrist	2 Pomperaug Office Park #202	Southbury	CT	06488		
Dileema Kalansuriya	Internist/Geriatrician	22 Old Waterbury Rd St 108	Southbury	CT	06488		
Andrew L. Rubman	Family Doctor/G.P.	900 Main St S	Southbury	CT	06488		
William N. Pearson	Cardiology	30 Quaker Farms Rd	Southbury	CT	06488		
Marina Zatman	Psychiatrist	385 Main St S #217	Southbury	CT	06488		
Lalaine Mortera, MD	Pediatric Medicine	22 Old Waterbury Rd Ste 204	Southbury	CT	06488		
Tamiko Jackson, MD	Pediatric Medicine	30 Quaker Farms Rd	Southbury	CT	06488		
Agata Jaskiewicz-Poznanska, MD	Family Medicine	22 Old Waterbury Rd Ste108	Southbury	CT	06488		
Fitzhugh Pannill, MD	Geriatric Medicine	22 Old Waterbury Rd Ste 201	Southbury	CT	06488		
Corinna Balanon- Sorian, MD	Pediatric Medicine	22 Old Waterbury Rd Ste 204	Southbury	CT	06488		
Barbara Brandes, MD	Pediatric Medicine	22 Old Waterbury Rd Ste 204	Southbury	CT	06488		
Douglas Hudson, MD	Family Medicine	900 Main St N	Southbury	CT	06488		
Jonathan Mosovich, MD	Internal Medicine	22 Old Waterbury Rd Ste 201	Southbury	CT	06488		
Neetu V. Nebhawani, MD	Internal Medicine	30 Quaker Farms Rd Ste 1	Southbury	CT	06488		
Joan Tekula	Podiatrist	2 Pomperaug Office Park #106	Southbuy	CT	06488		
Alexander Mbewe	Internal Medicine	209 Main St Ste C	Southington	CT	06489		
Mark Peterson	Pediatric Medicine	143 N Main St	Southington	CT	06489		
George Skarvinko	Pediatric Medicine	209 Main St Ste A	Southington	CT	06489		
Arthur Blumer, MD	Pediatric Medicine	340 N Main St	Southington	CT	06489		
Robert Rackliffe, MD	Pediatric Medicine	55 Meriden Ave Ste 3D	Southington	CT	06489		
Alina Osnaga, MD	Family Medicine	98 Main St Ste 301	Southington	CT	06489		
Sari Friedman, MD	Pediatric Medicine	101 N Main St	Southington	CT	06489		
Catherine Holmes, MD	Internal Medicine	209 Main St Ste C	Southington	CT	06489		
Letterio Asciuto, MD	Internal Medicine	70 Meriden Ave Fl 2	Southington	CT	06489		
Leonard Glaser Jr., MD	Internal Medicine	360 N Main St Ste 3	Southington	CT	06489		
Anthony Ciardella, MD	Internal Medicine	360 N Main St Ste 14	Southington	CT	06489		
Andrew Guest, MD	Internal Medicine	171 Liberty St	Southington	CT	06489		
Ronald Bezahler, MD	Internal Medicine	70 Meriden Ave	Southington	CT	06489		
Ralph Prezioso Jr., MD	Internal Medicine	70 Meriden Ave Fl 2	Southington	CT	06489		
Joseph Babiarz, MD	Internal Medicine	360 N Main St Ste 9	Southington	CT	06489		
Jordan Goetz, MD	Internal Medicine	98 Main St Ste 301	Southington	CT	06489		
Craig Bogdanski, DO	Internal Medicine	825 Meriden Waterbury Tpke	Southington	CT	06489		
Katarzyna Wadolowski	Internal Medicine	209 Main St Ste C	Southington	CT	06489		
George M Barchini	Internal Medicine	205 S Main St	Thomaston	CT	06790		
George Barchini, MD	Internal Medicine	19 Waterbury Rd	Thomaston	CT	06787		
Arthur Lebowitz, MD	Internal Medicine	130 S Main St	Thomaston	CT	06787		
Gary Schecter, MD	Family Medicine	131 Main St Ste 101A	Thomaston	CT	06787		
John Moschello, MD	Internal Medicine	130 S Main St	Thomaston	CT	06787		
Thomas P. Greco	Interal Medicine	133 Scovill St. 306 307	Waterbury	CT	06706	M-F: 9A-	
Suphichaya Muangman	Cardiovascular Disease	133 Scovill St. Suite 102	Waterbury	CT	06706	M-F: 8:30A-	

Arvind Suri	Internal Medicine	133 Scovill St.	Waterbury	CT	06706		
Ellen Mascoli	Internist/Geriatrician	160 Robbins St	Waterbury	CT	06708		
Karl Hartmann	Family Medicine	64 Robbins St.	Waterbury	CT	06708		
Ena Chow, MD	Pediatric Medicine	160 Robbins St	Waterbury	CT	06708		
Radhika Agrawal, MD	Pediatric Medicine	80 Phoenix Ave Ste 201	Waterbury	CT	06702		
Olena Ksovreli, MD	Internal Medicine	56 Franklin St Fl 3	Waterbury	CT	06706		
James Santacroce, MD	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
Shawn Cole	Internal Medicine	160 Robbins St	Waterbury	CT	06708		
Kalpesh Patel	Internal Medicine	64 Robbins St	Waterbury	CT	06705		
Cristina Tamasdan, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Sailaja Puttagunta, MD	Infectious Disease	56 Franklin St.	Waterbury	CT	06706		
Family Walk In Medical Center		2457 E Main St. Suite E	Waterbury	CT	06705	W&Th: 9A-7P Saturday & Sunday: 9A-4P	
Vidyapriya, Loganathan	Internal Medicine	2458 E Main St. Suite E	Waterbury	CT	06705	W&Th: 9A-7P Saturday & Sunday: 9A-4P	
Diane Swensen Miller	Family Practice	2457 E Main St. Suite E	Waterbury	CT	06705	M-F: 8A-5P Saturday &	
Balakrishnan Sathishchandar	Internal Medicine	2457 E Main St. Suite E	Waterbury	CT	06705	N/A	
Kanagaratnam, Jegathesan	Internal Medicine	2271 E Main St	Waterbury	CT	06705	M-F: 8A-5P	
Kanthimathi, Jegathesan	Internal Medicine	2271 E Main St.	Waterbury	CT	06705	M-F: 8A-5P	
Maximilian Gomez Trochez	Internal Medicine	2257 E Main St.	Waterbury	CT	06705	M-F: 8A-5P	
Philip A Mongelluzzo	Internal Medicine	2247 E Main St.	Waterbury	CT	06705	T&Th: 9A-5P W: 11A-7P F: 9A-4P	
Sanjay K Aggarwal	Interal Medicine	506 Frost Rd.	Waterbury	CT	06705	N/A	
Edmund Caporaso	Interal Medicine	1567 E Main St.	Waterbury	CT	06705	M-F: 9A-4:30P	
Joseph J Bowen	Hematology/Oncology	133 Scovill St. Suite 102	Waterbury	CT	06706	M-F: 9A-5P	
Peter C. Chien	Cardiovascular	13 Scovill St. Suite 102	Waterbury	CT	06706	N/A	
Ann Marie Conti-Kelly	Internal Medicine	133 Scovill St. 306 307	Waterbury	CT	06706	N/A	
Ken Matsuo	Internal Medicine	133 Scovill St. Suite 102	Waterbury	CT	06706	N/A	
Lakshmi Polisetty	Internal Medicine	133 Scovill St. Suite 102	Waterbury	CT	06706	M-F: 24/7 Sunday 8A-5P	
Saurabh Ranjan	Internal Medicine	133 Scovill St. Suite 102	Waterbury	CT	06706		
Santhi Singanamala	Internal Medicine	133 Scovill St.	Waterbury	CT	06706		
John Testa	Internal Medicine	133 Scovill St. Suite 102	Waterbury	CT	06706		
James Uberti	Internal Medicine	133 Scovill St. Suite 102	Waterbury	CT	06706		
Julia Zefirova	Internal Medicine	133 Scovill St. Suite 102	Waterbury	CT	06706		
Ronalad Zlotoff	Gastroenterology	133 Scovill St. Suite 102	Waterbury	CT	06706		
Dmity Albin	Interal Medicine	56 Franklin St	Waterbury	CT	06706		
Carlos Almeida	Interal Medicine	56 Franklin St	Waterbury	CT	06706		

Alexander J Alvarez	Interal Medicine	56 Franklin St	Waterbury	CT	06706		
Joseph R Anthony	Cardiovascular Disease	56 Franklin St	Waterbury	CT	06706		
Mary L Aquavia	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Carolina Iona Borz Baba	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Kathleen P Burlison	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Sallie A Carrington	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Monzurul Chowdhury	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Melisha G Cumberland	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Joseph Hsieh Donroe	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Benjamin R Doolittle	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Bernard T Dsouza	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Karen Eckardt	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Michael A Feinberg	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Arjet Gega	Infectious Disease	56 Franklin St	Waterbury	CT	06706		
Peter J Giacomazzi	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Chalmers M Hamill	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Mark L Kraus	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Daniel Leal	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Frank Kennison Longo	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Jaime P Moskowitz	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Aditi Mukherji	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Nathan Nartey	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Andreea Neamtu	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Rebecca Newell	Interal Medicine	56 Franklin St	Waterbury	CT	06706		
Jason Oullette	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Jessy Paul	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Edmund P Quinn	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Tracy Lyn Rabin	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Rey F Ramos	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Mark S Rosenberg	Cariovascular Disease	56 Franklin St	Waterbury	CT	06706		
Brian J Rosenhein	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Stephen Rubenstein	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Bechoi Saleib	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
John Albert Salerno	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Jaideep S Talwalkar	Pediatric Medicine	56 Franklin St	Waterbury	CT	06706		
Victorio G Te	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Sumit Tickoo	Interventional Cardiology	56 Franklin St	Waterbury	CT	06706		
He Zhang	Pulmonary Disease	56 Franklin St	Waterbury	CT	06706		
Joseph P Morley	Cardiovascular Disease	455 Chase PKWY	Waterbury	CT	06708		
Moses Aderanti	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
Muhammad Ijaz	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		

Lotachukwu Ojide	Family Practice	64 Robbins St.	Waterbury	CT	06708		
David J Pizzuto	Internal Medicine	1211 W Main St	Waterbury	CT	06708		
Olurotimi Adekolu	Internal Medicine	160 Robbins St	Waterbury	CT	06708		
Veronica Angulo Diaz	Internal Medicine	160 Robbins St	Waterbury	CT	06708		
David J Delucia	Internal Medicine	134 Grandview Ave	Waterbury	CT	06708		
Hector R Pun	Internal Medicine	134 Grandview Ave	Waterbury	CT	06708		
Ionut B Anton	Internal Medicine	171 Grandview Ave	Waterbury	CT	06708		
Ihsan I Jabbour	General Surgery	171 Grandview Ave Suite 105	Waterbury	CT	06708		
Thomas C Gniadek	Internal Medicine	1389 W Main St	Waterbury	CT	06708		
Roberto A Gobbee	Internal Medicine	1389 W Main St	Waterbury	CT	06709		
Denise M Kearney	Allergy/Immunology	1389 W Main St Suite 205	Waterbury	CT	06708		
Maysoun Richi	Internal Medicine	1389 W Main St Suite 322	Waterbury	CT	06708		
Lawrence E Scheer	Allergy/Immunology	714 Chase PKWY Suite 2	Waterbury	CT	06708		
Michael J Ackley	Podiatric Surgeon	80 Phoenix Avenue	Waterbury	CT	06702	3:00P T & Th 9A - 12P First two	
Wellmore	Behavioral Health	141 East Main St.	Waterbury	CT	06702		
Wheeler Clinic: loretta Staples	Behavioral Health	50 Brookeside Rd	Waterbury	CT	06708		
Greater Waterbury Mental Health	Behavioral Health	95 Thomaston Ave #2	Waterbury	CT	06702		
Staywell Health Center	Behavioral Health	1302 S Main St	Waterbury	CT	06706		
Advanced Podiatry Specialists	Podiatry	1389 W Main St Suite 222	Waterbury	CT	06708		
Sondra Bogursky	Internal Medicine	95 Scovill Ste 101B	Waterbury	CT	06706		
Diane Fountas	Pediatric Medicine	1389 W Main St STE 325	Waterbury	CT	06708		
Avik Chatterjee	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Sedat Shaban	Pediatric Medicine	1389 W Main St Ste 308	Waterbury	CT	06708		
Jane Rudolph	Pediatric Medicine	179 Roseland Ave	Waterbury	CT	06710		
Sandra Carbonari	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Allyson L. Rovetto	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Christopher Randolph	Pediatric Medicine	1389 W Main St Ste 205	Waterbury	CT	06708		
Ira Berg	Pediatric Medicine	160 Robbins St	Waterbury	CT	06708		
Charles Fischbein	Pediatric Medicine	160 Robbins St	Waterbury	CT	06708		
David H. Dreyfus	Pediatric Medicine	4 Clifton Ave	Waterbury	CT	06710		
Rebecca Eleck	Family Medicine	55 N Elm St	Waterbury	CT	06702		
Leor Zedek	Family Medicine	64 Robbins St.	Waterbury	CT	06708		
Christopher Loughlin	Family Medicine	60 Westwood Ave Ste 104	Waterbury	CT	06708		
Sarah Baum	Pediatric Medicine	160 Robbins St	Waterbury	CT	06708		
Maria Tasso	Pediatric Medicine	160 Robbins St	Waterbury	CT	06708		
Larry Deutsch, MD	Pediatric Medicine	80 Phoenix Avenue Ste 201	Waterbury	CT	06702		
Upulie Nawaratne, MD	Pediatric Medicine	80 Phoenix Ave Ste 101	Waterbury	CT	06702		
Lata Jayanthi, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Karen Kennedy, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Richard Shea, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		

Paul Teiger, MD	Pediatric Medicine	1389 W Main St	Waterbury	CT	06708		
Christine Maffeo, MD	Pediatric Medicine	179 Roseland Ave	Waterbury	CT	06710		
Erlinda Villaluz, MD	Pediatric Medicine	548 Willow St	Waterbury	CT	06710		
Philipe Chain, MD	Family Medicine	80 Phoenix Ave Ste 303	Waterbury	CT	06702		
Wasim Ghani, MD	Family Medicine	56 Franklin St Fl 5	Waterbury	CT	06706		
Andrew Whyte, DO	Emergency Medicine	56 Franklin St	Waterbury	CT	06706		
John Dieck, DO	Family Medicine	140 Grandview Ave	Waterbury	CT	06708		
Paolin Chi, MD	Pediatric Medicine	44 Regal Ct	Waterbury	CT	06705		
Michael Rokosky, MD	Pediatric Medicine	1404 W Main St	Waterbury	CT	06708		
Ali Vaezy, MD	Pediatric Medicine	56 Franklin St Ste 1	Waterbury	CT	06706		
Neysa McDonald, MD	Pediatric Medicine	160 Robbins St	Waterbury	CT	06708		
Alok Bhargava, MD	Pediatric Medicine	134 Grandview Ave Ste 208	Waterbury	CT	06708		
Felix Cabrera, MD	Family Medicine	64 Robbins St.	Waterbury	CT	06708		
Sonnel Patrick, MD	Pediatric Medicine	475 Chase Pkwy Ste 1	Waterbury	CT	06708		
Olatokunbo Famakinwa, MD	Pediatric Medicine	95 Scovill St	Waterbury	CT	06706		
Katherine Gielissen, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Sarah Gottfried, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Rachel Osborn, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Emily Pinto-Taylor, MD	Pediatric Medicine	95 Scovill St	Waterbury	CT	06706		
Samantha Smith, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Lacey Whitmire, MD	Pediatric Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Angela Quatrocelli, MD	Pediatric Medicine	56 Franklin St	Waterbury	CT	06706		
Karina Berg, MD	Geriatric Medicine	64 Robbins St.	Waterbury	CT	06708		
Susan Giles, MD	Geriatric Medicine	64 Robbins St.	Waterbury	CT	06708		
Neil Vitale, MD	Pediatric Medicine	160 Robbins St	Waterbury	CT	06708		
Shirin Mahooti, MD	Pediatric Medicine	1389 W Main St Ste 207	Waterbury	CT	06708		
Kristen Gates, MD	Family Medicine	80 Phoenix Ave	Waterbury	CT	06702		
Jaime Stevens, MD	Family Medicine	51 N Elm St Fl 5	Waterbury	CT	06702		
Hamsa Jayaraj, MD	Geriatric Medicine	47 Country Club Woods Cir	Waterbury	CT	06708		
Shalini Keswani, MB	Pediatric Medicine	80 Phoenix Ave Ste 303	Waterbury	CT	06702		
Neil Miller, MD	Geriatric Medicine	500 Chase Pkwy Ste 3	Waterbury	CT	06708		
Joseph Fahey, MD	Pediatric Medicine	80 Phoenix Ave Ste 201	Waterbury	CT	06702		
Aroonsiri Sangarlangkarn, MD	Geriatric Medicine	64 Robbins St.	Waterbury	CT	06708		
Adepeju Champion, MD	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
David Delucia, MD	Internal Medicine	134 Grandview Ave Ste 202	Waterbury	CT	06708		
Dragoslav Drca, MD	Internal Medicine	1320 W Main St Ste 1	Waterbury	CT	06708		
Melvyn Ranish, MD	Internal Medicine	475 Chase Pkwy Ste 1	Waterbury	CT	06708		
Stephen Spear, MD	Internal Medicine	1302 S Main St	Waterbury	CT	06706		
Donald Rosenthal, MD	Internal Medicine	1981 E Main St # 2	Waterbury	CT	06705		
Shiven Chabria, MD	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
Lynn Phillips, MD	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
Jaime Ruszkowski, MD	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		

Joseph Soufer, MD	Internal Medicine	500 Chase Pkwy	Waterbury	CT	06708		
Jennifer Ongchin, DO	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
Zife Krosi, MD	Internal Medicine	80 Phoenix Ave Ste 303	Waterbury	CT	06702		
Ottilie Rose, MD	Pediatric Medicine	95 Scovill St	Waterbury	CT	06706		
Christopher Watts, MD	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
Leonardi Koliani, MD	Internal Medicine	500 Chase Pkwy	Waterbury	CT	06708		
Pingali Chandra Mohan	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Adnan S Sadiq, MD	Internal Medicine	80 Phoenix Ave Ste 303	Waterbury	CT	06702		
Pavan Jain, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Evgeny Kirsanov, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Shahin Shahnia, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Swapna Velamakanni, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Shawnette Alston, MD	Internal Medicine	133 Scovill St Ste 102	Waterbury	CT	06706		
Michael Ashwood, MD	Internal Medicine	56 Franklin St Ste 1	Waterbury	CT	06706		
Sybil Vheng, DO	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Lucinda Fingado, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Guy Fish, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Stephen Holland, MD	Internal Medicine	56 Franklin St Ste 2	Waterbury	CT	06706		
Saritha Kolli, DO	Internal Medicine	56 Franklin St Ste 1	Waterbury	CT	06706		
Winston Magno, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Brian Rosenhein, DO	Internal Medicine	56 Frankling St Ste 3	Waterbury	CT	06706		
Tiffany Sanders, MD	Internal Medicine	56 Franklin St Ste 1	Waterbury	CT	06706		
Grace Totoe, MD	Internal Medicine	56 Frankling St	Waterbury	CT	06706		
David Elson, MD	Internal Medicine	64 Robbins St.	Waterbury	CT	06708		
Sue-Ellen Franklyn, MD	Internal Medicine	64 Robbins St. Fl 3	Waterbury	CT	06708		
Gregory Kresel, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Unnati Mehta, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Johnny Mei, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Jonathan Nunez, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Jorge Otero, MD	Emergency Medicine	64 Robbins St	Waterbury	CT	06708		
Carolyn Presley, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Jorge Ramos, DO	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
William Rifkin, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Isaac Shalom, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Curtis Tate, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Gary Tickey, MD	Emergency Medicine	64 Robbins St	Waterbury	CT	06708		
Anupama Voodarla, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Yvonne Smith, MD	Internal Medicine	67 Farrington Ave	Waterbury	CT	06706		
Steven Herzig, MD	Internal Medicine	506 Frost Rd.	Waterbury	CT	06705		
John Salerno, MD	Internal Medicine	60 Westwood Ave Ste 250	Waterbury	CT	06708		
Dr. Bechoi Saleib, MD	Internal Medicine	1981 E Main St # 2	Waterbury	CT	06705		
Seth Clohosey, MD	Internal Medicine	56 Franklin St Ste 1	Waterbury	CT	06706		

Joseph Deluca, MD	Internal Medicine	500 Chase Pkwy	Waterbury	CT	06708		
Vania Reyes, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Julie Rosenbaum, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Lisa Sanders, MD	Internal Medicine	160 Robbins St	Waterbury	CT	06708		
David Pizzuto, MD	Internal Medicine	1211 W Main St Lowr 2	Waterbury	CT	06708		
Chinedu A. Igwe, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Jakub Wojcik, MD	Internal Medicine	56 Franklin St Ste 1	Waterbury	CT	06705		
Sita Singhal, DO	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Sadie Barchini, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Jyoji Bristole, MD	Internal Medicine	2247 E Main St.	Waterbury	CT	06705		
Vidya Loganathan, MD	Internal Medicine	506 Frost Rd.	Waterbury	CT	06705		
Richard Meo, MD	Family Medicine	18 Cliff St	Waterbury	CT	06710		
Joseph Reynolds, MD	Family Medicine	133 Scovill St	Waterbury	CT	06706		
Joseph Pruner, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Navin Gazi, MB BS	Family Medicine	64 Robbins St	Waterbury	CT	06708		
Victor Wasilauskas, MD	Internal Medicine	8 S Commons Rd	Waterbury	CT	06704		
Nicole Maksymiw, DO	Internal Medicine	80 Phoenix Ave	Waterbury	CT	06702		
Oltjon Albajrami, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Avijit Baidwan, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Gretchen Berland, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Suvarna Choudhari, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Daniel Cottrell, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Nishil Dalsania, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Claire Li, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Alan Malina, MD	Internal Medicine	95 Scovill St Fl 2	Waterbury	CT	06706		
Joshua Mosdale, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Jaime Moskowitz, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Peter Moyer, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Chisom Onuoha, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Michael Simms, MD	Infectious Disease	56 Franklin St	Waterbury	CT	06706		
Paul Preissler, MD	Thoracic Surgery	56 Franklin St.	Waterbury	CT	06706		
Robert Anthony, MD	Cardiovascular Disease	56 Franklin St.	Waterbury	CT	06706		
Gregory Colodner, MD	Sleep Medicine	56 Franklin St.	Waterbury	CT	06706		
Paul Kelly, MD	Cardiovascular Disease	56 Franklin St.	Waterbury	CT	06706		
Rebecca Scandrett, MD	Cardiovascular Disease	56 Franklin St.	Waterbury	CT	06706		
Azhar Imam, MD	Psychiatrist	56 Franklin St.	Waterbury	CT	06706		
Mouhamed Ndiaye, MD	Psychiatrist	56 Franklin St.	Waterbury	CT	06706		
Richard Putnam, DMD	General Practice	56 Franklin St.	Waterbury	CT	06706		
Claire Toon, DDS	General Practice	56 Franklin St.	Waterbury	CT	06706		
Nicole Sookan, MD	Surgical Oncology	56 Franklin St.	Waterbury	CT	06706		
Mitcehl Chere, MD	Obstetrics/Gynecology	56 Franklin St.	Waterbury	CT	06706		
Aziz Richi, MD	Thoracic Surgery	56 Franklin St.	Waterbury	CT	06706		

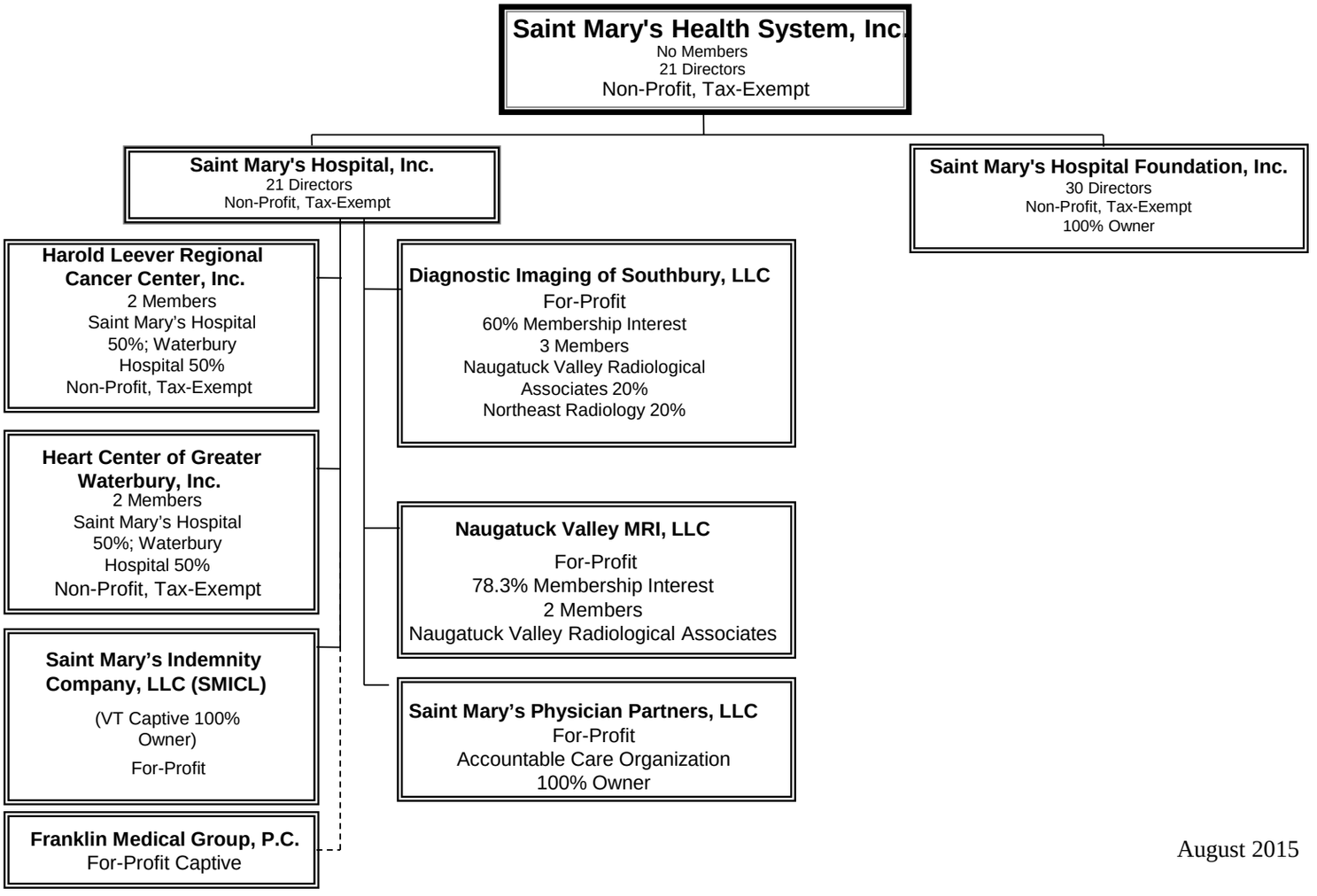
Shady Macaron, MD	General Surgery	56 Franklin St.	Waterbury	CT	06706		
Philip Corvo, MD	General Surgery	56 Franklin St.	Waterbury	CT	06706		
Alexander Palesty, MD	General Surgery/Surgical Oncology	56 Franklin St.	Waterbury	CT	06706		
Robert Wetmore, MD	Orthopedic Surgery	56 Franklin St.	Waterbury	CT	06706		
Bhupinder Lyall, MD	Gastroenterology	56 Franklin St.	Waterbury	CT	06706		
Patrick Schofield, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Omer Sharif, MD	Internal Medicine	95 Scovill St Fl 2	Waterbury	CT	06706		
Germine Soliman, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Erin Vaughn, MD	Internal Medicine	95 Scovill St Fl 3	Waterbury	CT	06706		
Mujeeb Altaf, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Daniyal Ansari, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Natasha Bhimani, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Rabia Cheema, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Vanessa Goyes-Ruiz, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Michael Holliday Jr., MD	Internal Medicine	56 Franklin St.	Waterbury	CT	06706		
Jessica Hychko, MD	Internal Medicine	56 Franklin St.	Waterbury	CT	06706		
Nasheena Jiwa, MD	Internal Medicine	56 Franklin St. Ste 1	Waterbury	CT	06706		
Nicole Joyce, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Karim Kara, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Faraz Khan, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Diane Kim, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Daniel Leal, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Joseph McCullough, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Peter O'Connor, DO	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Jomeo Padavil, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Chandra Rednam, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Daren Spinelle, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Ross Varma, MD	Internal Medicine	56 Franklin St	Waterbury	CT	06706		
Erica Martinucci, MD	Internal Medicine	146 Highland Ave Ste 1	Waterbury	CT	06708		
William Becker, MD	Internal Medicine	64 Robbins St	Waterbury	CT	06708		
Alliance Medical Group	Internal Medicine	160 Robbins St	Waterbury	CT	06708		
Scoville Medical Group PC	Internal Medicine	133 Scovill St #201	Waterbury	CT	06706		
Cardiology Associates of Waterbury	Cardiovascular Disease	455 Chase PKWY	Waterbury	CT	06708		
Heart Center of Greater Waterbury	Cardiovascular Disease	1075 Chase Pkwy	Waterbury	CT	06708		
Waterbury Orthopedic Associates	Orthopedics	1211 W Main St #1	Waterbury	CT	06708	M-F: 8:30A-5P	
Neurosurgery Othopaedics & Spine Specialists, PC (NOSS)	Neurology/Orthopedics	500 Chase Pkwy	Waterbury	CT	06708		
Waterbury Outpatient Surgical Center	Opthalmology/Plastic Surgery	87 Grandview Ave	Waterbury	CT	06708		
Associated Women's Health Specialists	Women's Health	140 Grandview Ave #202	Waterbury	CT	06708		

Naugatuck Valley Ob-Gyn Associates	Obstetrics/Gynecology	133 Scovill St #303	Waterbury	CT	06706		
Digestive Disease Center of Ct	Gastroenterology	60 Westwood Ae #314	Waterbury	CT	06708		
Quest Diagnostics	Lab Draw Station	60 Westwood Ave	Waterbury	CT	06708	M-F: 8A-5P	
Quest Diagnostics	Lab Draw Station	1389 W Main St #125	Waterbury	CT	06708		
Quest Diagnostics	Lab Draw Station	2457 E Main St, Sunbeam Ave	Waterbury	CT	06705		
Franklin Faculty Practice	Various	133 Scovill St.	Waterbury	CT	06706		
Waterbury Hospital	Acute Care Hospital	64 Robbins St	Waterbury	CT	06708		
Counseling Center of Waterbury	Behavioral Health	525 Wolcott St	Waterbury	CT	06705	M-F: 9A-9P	
203 Urgent Care	Urgent Care Medicine	279 Chase Ave	Waterbury	CT	06704	M-F: 8A-8P	
203 Urgent Care	Urgent Care Medicine	506 Frost Rd.	Waterbury	CT	06705	M-F: 8A-8P	
Concentra Urgent Care	Urgent Care Medicine	8 S Commons Road	Waterbury	CT	06704	M-F: 7A-6P	
Da Vita Inc	Dialysis Center	209 Highland Ave	Waterbury	CT	06708		
Wound Healing Center	Wound Care	56 Franklin St	Waterbury	CT	06706		
Peak Physical Therapy	PT	279 Chase Ave	Waterbury	CT	06704	M-F: 7A-7:30P	
Physical Therapy & Sports Medicine Centers	PT	1211 W Main St	Waterbury	CT	06708		
Access Rehab Centers	PT	715 Lakewood Rd #3	Waterbury	CT	06704	T&Th: 8A-7P Saturday: 8A-12P	
Saint Mary's Hospital PT/OT	PT/OT	1981 East Main Street	Waterbury	CT	06705		
Center for Hand Surgery: Beauvais, Paul, MD	Hand Surgery	60 Westwood Ave #300	Waterbury	CT	06708		
Nagatuck Valley Ear Nose: Jerome Sugar, MD	Ear, Nose, Throat	171 Grandview Ave #201	Waterbury	CT	06708		
Pro Health Physicians	Various	500 Chase Pkwy #3	Waterbury	CT	06708		
Waterbury Orthopaedics: Eric Olson, MD	Orthopedics	1211 W Main St #1	Waterbury	CT	06708		
Bidarkote Somanath, MB	Pediatric Medicine	140 Grandview Ave Ste 206	Waterbury	CT	06708		
Ronald D'Andrea	Internal Medicine	51 Depot St Ste 506	Watertown	CT	06795		
Ephriam Bartfeld	Pediatric Medicine	380 Main St	Watertown	CT	06795		
Abdelsalam Ahmed, MD	Family Medicine	77 Oak St	Watertown	CT	06795		
Jeffrey Stern, MD	Internal Medicine	51 Depot St Ste 201	Watertown	CT	06795		
John McHugh, MD	Internal Medicine	51 Depot St Ste 202	Watertown	CT	06795		
Mary Jane Brackett, MD	Family Medicine	45 Litchfield Rd	Watertown	CT	06795		
Sujai D Nath	Neurology	182 Garrigus Court	Wolcott	CT	06716	M-F: 8A-5P	
Laura C Brenes Dorso	Internal Medicine	464 Wolcott	Wolcott	CT	06716		
Marc N Raad	Internal Medicine	503 Wolcott Rd	Wolcott	CT	06716		
Martin R. Canillas	Sports Medicine	509 Wolcott Rd	Wolcott	CT	06716		
Joseph Brenes	Internal Medicine	464 Wolcott Rd	Wolcott	CT	06716		
Austin C Shealy	Internal Medicine	40 Main St N	Woodbury	CT	06798		
Jose Buhain, MD	Pediatric Medicine	19 Judson Ave Apt 5D	Woodbury	CT	06798		
Andrea Needleman, MD	Family Medicine	4 S Pomperaug Ave	Woodbury	CT	06798		

Charles McNair, MD	Geriatric Medicine	40 Main St N	Woodbury	CT	06798		
William Schmidt, MD	Internal Medicine	183 Washington Rd	Woodbury	CT	06798		

EXHIBIT S1

Corporate Structure



August 2015

EXHIBIT S2

March 24, 2016

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

Re: Notice that Franklin Medical Group, P.C. is Filing a Certificate of Need with the Office of Health Care Access to Change Ownership.

Dear Attorney General Jepsen,

Pursuant to Sections 27 (c) and (d) of Public Act 15-146, this letter will serve as notice that Franklin Medical Group, P.C., ("FMG") a for-profit affiliate of Saint Mary's Hospital ("the Hospital") in Waterbury, is filing a certificate of need ("CON") application with the CT DPH Office of Health Care Access ("OHCA") for approval of its plan to remain with Saint Mary's Hospital as the Hospital and its affiliates move to become a part of the Trinity Health Corporation's New England Regional Health Ministry ("THNE-RHM"). THNE-RHM was formerly known as Saint Francis *Care*, Inc. The Hospital and THNE-RHM have filed a CON application with OHCA regarding their merger transaction (Docket No. 15-32045), which has not yet been deemed complete.

There are approximately ninety physicians in the FMG practice, which is a captive professional entity and an affiliate of Saint Mary's Hospital. FMG was established by the Hospital and has worked collaboratively with the Hospital since inception, providing outstanding care for the patients in Waterbury and the surrounding towns in its service area. If the CON is approved, FMG will continue to operate in the same locations as currently exist, and will remain an affiliate of Saint Mary's Hospital.

A.) THNE-RHM will become the sole corporate member of the Hospital through a transfer agreement, after which THNE-RHM will serve as the parent of the Hospital. FMG is a for-profit affiliate of Saint Mary's Hospital. As a result of SMHS's organizational change, there will be a change in the governance structure/ultimate controlling entity of FMG from the Hospital to THNE-RHM that is within the statutory definition of "transfer of ownership". Section 19a-630(16), C.G.S. FMG will remain an affiliate of the Hospital. The change of ownership of the Hospital will affect the physician group only in terms of the ultimate control of the health network within which the physicians will be working. The FMG physicians intend to continue serving their patients in Waterbury and the towns surrounding Waterbury in the Hospital's defined service area. No cash purchase is contemplated. If the

proposed transaction is approved, Trinity Health through the THNE-RHM will make substantial operational and financial commitments to the Hospital and the communities it serves, which in turn will benefit the FMG physicians in an indirect manner.

B.) The names and specialties of each physician who are members of FMG are attached as Exhibit A.

C.) The names of the business entities that are to provide services following the effective date of the transfer are:

Franklin Medical Group, P.C.: Providing Direct Patient Care
Steven Schneider, MD, President
John Testa, MD, Chief Medical Officer
Donald Jansen, Interim Executive Director
(and the physicians listed in Exhibit A).

Trinity Health - New England, Inc. (fka Saint Francis *Care* Inc.):
Christopher Dadlez, FACHE, President and Chief Executive Officer
Daniel Moen, Chief Operating Officer
David Bittner, Chief Financial Officer

Trinity Health Corporation:
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, EVP, Growth, Strategy and Innovation

D.) The following are the locations where the FMG physicians practice:

APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Days/Hours of Operation
Breast & Oncology	33 Bullet Hill Rd. Southbury	M - F, 8:30 - 4:30
Cardiology	1320 West Main St. Waterbury	M - F, 8:30 - 4:30
Cardiology	56 Franklin St., Waterbury	M - F, 8:30 - 4:30
Pulmonary	133 Scovill St. Ste.104 Waterbury	M - F, 8:30 - 4:30
Gastroenterology	140 Grandview Ave.	M - TH, 8:30 - 4:30,

	Waterbury	Closed Friday
Sleep Medicine	1320 West Main St. Waterbury	M - TH, 8:45 - 5, Fri. 8 - 12
Primary Care	70 Heminway Park Rd. Watertown	M - F, 8 - 5
Infectious Disease	133 Scovill St. Ste.102, Waterbury	M - F, 8-4:30
Primary Care	503 Wolcott Rd. Wolcott	M - F, 8-4
Primary Care	503 Wolcott Rd. 2nd Floor Wolcott	M - F, 9-5
Primary Care	117 New Haven Rd. Naugatuck	M, W, Th, F 7 - 4:30; Tues 7 - 6:30
Primary Care	133 Scovill St. Ste.102, Waterbury	M - F, 8-4:30
Primary Care	1981 East Main St. Waterbury	M - TH 8:30 - 5, Fri 8:30 - 2
Primary Care	95 Scovill Street Pavillion B, Waterbury	M - F, 8 - 5:30
Pediatrics	95 Scovill Street Pavilion B, Waterbury	M - F, 8 - 5:30
Pediatrics	166 Waterbury Rd. Prospect	M,T, Fri, 8 - 5, W & TH 8 - 7:30
Primary Care	166 Waterbury Rd. #300 Prospect	M - F, 8-5
Breast & Oncology	166 Waterbury Rd. #300 Prospect	M - F, 8:30 - 5
GYN	167 Waterbury Rd. #300 Prospect	M - F, 7:30 - 3
Ortho PA	133 Scovill St. Ste.308 Waterbury	W 8:30 - 4:30
Surgery	133 Scovill St. Ste.303 & 308 Waterbury	M - F, 8:30 - 4:30
Surgery	590 Middlebury Rd. #A Middlebury	M - F, 8:30 - 4:30
Gastroenterology	60 Westwood Ave #314 Waterbury	M - F, 8:30 - 4:30
Oncology/Hematology	1075 Chase Parkway Ste A Waterbury	M - F, 9 - 5
Primary Care	714 Chase Parkway Suite 6 Waterbury	M, W, Th, F 8:30 - 5; Tues 8:30 - 5:15
Breast & Oncology	900 Main Street South Bldg. 2 Ste 101 Southbury	M - F, 8:30 - 4:30
Primary Care	60 Westwood Ave #250 Waterbury	M & W, 8:30 - 4:30, Th & Fri 8:30 -3:30, Closed Tuesday
Primary Care	385 Main Street South, Ste 106, Southbury	M - F, 9 - 5
Rheumatology/Primary Care	133 Scovill St. Suite 306, Waterbury	M - F, 8- 5

Dental	133 Scovill St. Suite 209, Waterbury	M - F, 8:30 - 4:30
Primary Care	1389 West Main St. Ste. 224, Waterbury	M 8 - 4:30, T 8 - 4:30, W 8:30-4:30, TH 8 - 4, F 8:30-12:30 (2nd + 4th) Closed 1st + 3rd

E.) Please see the above table for the services that are provided at each of the FMG locations.

F.) The primary service area within which the FMG physicians provide health services are Waterbury and the towns surrounding Waterbury.

> Saint Mary Hospital 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).

If you have any questions regarding FMG with regard to this notice or any other questions, please do not hesitate to call me or correspond directly with me so that you have all of the information you need.

Respectfully submitted,

Steven Schneider, MD, President
Franklin Medical Group, P.C.

EXHIBIT S3

AMENDED AND RESTATED

BYLAWS

OF

FRANKLIN MEDICAL GROUP, P.C.

ARTICLE I

NAME AND LOCATION

1. Name. The name of the Corporation is Franklin Medical Group, P.C. (hereinafter the "Corporation")

2. Principal Office. The board of directors may from time to time designate such place or places as the principal office and for the transaction of corporation business as it may determine.

ARTICLE II

CAPITAL STOCK

1. Stock Certificates: All certificates of stock shall be signed by the chairman, vice chairman, president or a vice president and by the secretary, assistant secretary, treasurer or assistant treasurer of the Corporation and sealed with the corporate seal or a facsimile thereof.

2. Stock Transfer. Transfers of stock shall be made only on the books of the Corporation and the old certificate, properly endorsed shall be surrendered and canceled before a new certificate is issued. Any such transfer must comply with Article XI.

3. Stock Books. The stock books of the Corporation shall be closed against transfers of stock for a period of five (5) days before the date of payment of a dividend and before each annual meeting of the shareholders.

4. Lost Certificates. The board of directors may, in case any share certificate is lost, stolen, destroyed or mutilated, authorize the issuance of a new certificate in lieu thereof, upon such terms and conditions, including reasonable indemnification of the Corporation, as the board of directors shall determine.

ARTICLE III

MEETINGS OF SHAREHOLDERS

1. Annual Meeting. The annual meeting of shareholders shall be held on such day during the second month after the end of the Corporation's fiscal year as the board of directors shall determine, at such hour as shall be specified in the notice of the meeting. The annual meeting shall be held at the principal office of the Corporation, or at such other place as shall be designated by the board of directors. At such meeting the shareholders shall elect the directors and transact such other business as may be properly brought before the meeting.

2. Special Meetings. Meetings of shareholders for any purpose may be held at such time or place within or without the State of Connecticut as shall be stated in the notice of the meeting or in a duly executed waiver of notice. A special meeting of the shareholders may be called by the president, or by a majority of the directors, and shall be held at any time upon call by the president or secretary when either the president or secretary is requested in writing to call such meeting by a majority of the directors or one or more shareholders holding not less than one-tenth of the voting power of all shares entitled to vote at the meeting.

3. Notice and Waiver. Notice of the time and place of all annual and special meetings of shareholders shall be mailed or delivered by the secretary to each shareholder entitled to vote at such meeting not less than seven nor more than fifty days before the date thereof, but this requirement as to notice may be waived at any time by the shareholders in writing. The attendance of any person at a meeting without protesting prior to the

commencement of the meeting the lack of proper notice shall be deemed to be a waiver by him of notice of the meeting.

4. Presiding Officer. The president of the Corporation, or in the absence of the President, such other officer or shareholder as shall be designated by the shareholders present, shall preside at shareholder meetings.

5. Voting and Proxies. At every meeting, each shareholder shall be entitled to one vote for each outstanding share of stock, regardless of class, held in his name, which vote may be cast in person or by proxy, on each matter submitted to a vote at such meeting of shareholders, unless, and except to the extent that voting rights of shares of any class are increased, limited or denied by the certificate of incorporation. Persons holding stock in a fiduciary capacity shall have the same voting rights upon shares of stock so held as any holder of shares would have. All votes shall, if requested by the presiding officer or by any shareholder, be by ballot, and the name of each shareholder voting shall be written thereon with the number of shares held by him. Any shareholder may designate an agent to vote at shareholder meetings, by a writing signed by him for that purpose, and such proxy shall entitle the person thus authorized to vote at all meetings of the shareholders held during the eleven months next succeeding the date of such instrument unless a longer or shorter term is expressly provided therein.

6. Quorum and Adjournment. The holders of a majority of the issued and outstanding shares entitled to vote present, in person or by proxy, at any meeting of shareholders shall constitute a quorum for such meeting except as may otherwise be provided in these bylaws, in the certificate of incorporation or in the Connecticut Stock Corporation Act. If, however, a quorum shall not be present in person or represented at any meeting of the shareholders, shareholders present in person or represented by proxy shall have power to adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present or represented. At such adjourned meeting at which a quorum shall be present or represented any business may be transacted which might have been transacted at the meeting as originally noticed.

7. Action by Shareholders. Except as may otherwise be specifically provided in these bylaws, in the certificate of incorporation or in the Connecticut Stock Corporation Act, the affirmative vote, at a meeting of shareholders duly held and at which a quorum is present, of a numerical majority of the voting power of all the shares entitled to vote on the subject matter shall be the act of the shareholders.

8. Action Without a Meeting. Any action which may be taken at a meeting of the shareholders may be taken without a meeting if a consent in writing, setting forth the action so taken or to be taken, shall be signed by all of the shareholders entitled to vote with respect to the subject matter thereof and said consent shall be filed in the minute book of the Corporation.

ARTICLE IV

DIRECTORS

1. Authority, Number and Qualifications. The business property and affairs of the Corporation shall be under the care and management of its board of directors. Directors need not be shareholders and need not be residents of Connecticut. The Corporation shall have not more than fifteen (15) and or less than three (3) directorships, except that when all the issued and outstanding shares of common stock of the Corporation are owned beneficially and of record by less than three (3) shareholders, the number of directorships may be less than three (3) but not less than the number of shareholders. The number of directorships shall be the number fixed by resolution of the shareholders or directors, or, in the absence thereof, shall be the number of directors ejected at the preceding annual meeting of shareholders.

2. Quorum. Adjournment and Action by Board of Directors. A numerical majority of the directors at the time shall constitute a quorum for the transaction of business; and the act of a numerical majority of the directors shall be the act of the board of directors, unless the presence of or act of a greater number is specifically required by these bylaws, the certificate of incorporation or the Connecticut Stock Corporation Act. If a quorum shall not be present at any

meeting of directors, the directors present thereat may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3. Action Without a Meeting. Any action which may be taken at a meeting of the directors may be taken without a meeting if a consent in writing, setting forth the action so taken, or to be taken, shall be signed by all of the directors entitled to vote with respect to the subject matter thereof and the number of such directors constitutes a quorum for such action. Such consent shall be filed with the minutes of the directors' meetings.

4. Meeting By Conference Telephone. A director or a member of a committee of the board of directors may participate in a meeting of the board of directors or of such committee by means of conference telephone or similar communications equipment enabling all directors participating in the meeting to hear one another, and participation in a meeting shall constitute presence in person at such meeting.

5. Terms and Vacancies. The directors, other than the first board of directors, shall be elected annually, at the annual meeting of the shareholders for a term extending until the next annual meeting of the shareholders; and each director shall hold office for the term for which he is elected and until his successor has been elected and qualified. Any vacancy or vacancies occurring in the board, other than a vacancy created by an increase in the number of directorships, may be filled for the unexpired term by action of the sole remaining director in office or by the concurring vote of a majority of the remaining directors in office, though such remaining directors are less than a quorum, though the number of directors at the meeting is less than a quorum, and though such majority is less than a quorum. If a vacancy or the vacancies are not filled by the directors, they shall be filled by election at an annual meeting, or at a special meeting of shareholders called for that purpose. A director elected to fill a vacancy shall be elected for the unexpired portion of the term of his predecessor in office. Any directorship to be filled because of an increase in the number of directors shall be by election at an annual meeting or at a special meeting of shareholders called for that purpose. A director elected to fill a .newly

created director-ship shall serve until the next succeeding annual meeting of shareholders and until his successor shall have been elected and qualified

6. Annual and Special Meetings. Annual meetings of the directors shall be held immediately after the annual meeting of the shareholders; and regular and special meetings of the directors may be held at such times and places, either within or without Connecticut, as, in the opinion of the president or a majority of the directors, the interests of said Corporation shall require, reasonable notice having been given thereof. A written waiver signed at any time by the person or persons entitled to notice shall be the equivalent to the giving of notice. The attendance of any director at a meeting without protesting prior to the commencement of the meeting the lack of proper notice shall be deemed to be a waiver by him of notice of the meeting.

7. Removal of Directors. Any director may be removed with or without cause at any time by the act of shareholders; and the vacancy in the board caused by any such removal may be filled by the act of the shareholders.

8. Executive and Other Committees. The board, by resolution adopted by the affirmative vote of directors holding a majority of the directorships, may designate two or more directors to constitute an executive committee or other committees, which committees shall have and may exercise such authority as is delegated to them by the board. The members of the executive committee may elect a chairman from among their number to preside over meetings of the executive committee.

ARTICLE V

OFFICERS

1. Number, Qualifications, Term and Election. The officers of the Corporation shall consist of a president, secretary, treasurer, chairman, and vice chairman. The directors may, in addition to the foregoing officers, appoint one or more vice presidents, one or more assistant treasurers, and one or more assistant secretaries. The directors shall appoint the officers of the

Corporation and officers need not be shareholders, and need not be residents of Connecticut. Any two or more offices may be held by the same person except the offices of president and secretary. Officers shall be appointed at the annual directors' meeting for a term extending until the next annual directors' meeting. Each officer shall hold office for the term for which he is appointed and until his successor has been appointed and qualified. Any vacancy or vacancies occurring in any office of the Corporation may be filled for the unexpired term by action of the sole remaining director in office or by the concurring vote of a majority of the remaining directors in office, though such remaining directors are less than a quorum, though the number of directors at the meeting are less than a quorum, and though such majority is less than a quorum.

2. President. It shall be the duty of the president to be the chief executive officer of the Corporation and he shall have general supervision over the business of the Corporation, subject to the control of the board of directors. He shall preside at each meeting of the shareholders. He shall see that all orders and resolutions of the board are carried into effect. In general, he shall perform all duties incident to the office of president and such other duties as may from time to time be assigned to him, or specifically required to be performed by him, by these bylaws, by the board of directors or by law.

3. Vice President. It shall be the duty of the vice president, in the absence of the president, to perform the president's duties, and such officer shall also perform such other duties as may be assigned to him, or specifically required to be performed by him, by these bylaws, by the board of directors or by the president.

4. Secretary. It shall be the duty of the secretary to act as secretary of and keep the minutes of all meetings of the board of directors and of shareholders; to cause to be given notice of all meetings of shareholders and directors; to be custodian of the seal of the Corporation and to affix the seal, or cause it to be affixed, to all certificates for shares of stock of the Corporation and to all documents, the execution of which on behalf of the Corporation under its seal, shall have been specifically or generally authorized by the board of directors; to have charge of the record of shareholders and also of the other books, records and papers of the Corporation relating

to its organization as a Corporation and to see that the reports, statements and other documents required by law are properly kept or filed; and in general, to perform all the duties incident to the office of secretary and such other duties as may from time to time be assigned to him by the board of directors or by the president.

5. Assistant Secretary. It shall be the duty of the assistant secretary, in the absence of the secretary, to perform the secretary's duties, and such officer shall also perform such other duties as may be assigned to him or specifically required to be performed by him, by the board of directors or by the president.

6. Treasurer. It shall be the duty of the treasurer to receive and keep the cash, funds and notes belonging to the Corporation and enter regularly in books kept for that purpose all monies received and disbursed on account of the Corporation. He shall also perform such other duties as may be assigned to him, or specifically required to be performed by him, by the board of directors or by the president.

7. Assistant Treasurer. It shall be the duty of the assistant treasurer, in the absence of the treasurer, to perform the treasurer's duties and such officer shall also perform such other duties as may be assigned to him, or specifically required to be performed by him, by the board of directors or by the president.

8. Chairman of the Board of Directors: The chairman of the board of directors shall preside at all meetings of the board of directors and shall be entitled to vote on all matters. The chairman of the board of directors is empowered to sign all contracts, deeds, and other instruments requiring signature in the Corporate name, and is empowered to sign and endorse for the Corporation in the transaction of its business, checks, drafts, notes and bills of exchange, and is empowered to appoint and remove, employ and discharge and fix the compensation of all agents and employees of the Corporation other than the duly elected officers, subject to the approval of the board of directors. The board of directors shall have the power to authorize some other officer or agent also to perform some or all of said functions. The chairman of the board of directors shall enforce these bylaws, shall perform all duties incident to the position and office

which are required by law, and shall require that the books, reports, statements and certificates required by law are properly kept, made and filed.

9. Vice Chairman of the Board of Directors: The vice chairman of the board of directors shall be entitled to vote on all matters. During the absence or inability of the chairman to render or perform his duties or exercise his powers, the same shall be performed and exercised by the vice chairman, and when so acting he shall have all the powers and be subject to all the responsibilities hereby given to or imposed upon the chairman.

10. Removal: Any officer of the Corporation may be removed, with or without cause, at any time by resolution adopted by the affirmative vote of directors holding a majority of the directorships.

ARTICLE VI

AMENDMENTS

These bylaws may be repealed or amended only by the shareholders and such repeal or amendment of bylaws by shareholders shall require the affirmative vote of a majority of the voting power of shares entitled to vote thereon. No existing bylaws shall be amended or repealed unless written notice of such proposed action shall have been given in the call for the meeting of shareholders at which such amendment or repeal is to be acted upon.

ARTICLE VII

SEAL

The seal of the Corporation shall be circular in form and shall contain the name of the Corporation and the words "Seal Connecticut”.

ARTICLE VIII

BOOKS AND RECORDS

There shall be kept correct and complete books and records of account and minutes of the proceedings of the Corporations shareholders and directors. There shall also be maintained at the principal office of the Corporation a record of the Corporation's shareholders, giving the names and addresses of all shareholders and the number and class of shares held by each.

ARTICLE IX

FISCAL YEAR

The fiscal year of the Corporation shall be fixed by action of the Board of Directors.

ARTICLE X

RESTRICTIONS ON BUSINESS ACTIVITIES

The business and activities to be conducted by this Corporation shall be limited to:

1. The practice of medicine.
2. The investment of its funds in real estate, mortgages, stocks, bonds or other types of investments.
3. The owning of real or personal property incident to the conduct of the practice of medicine.

ARTICLE XI

RESTRICTIONS ON TRANSFERS OF STOCK

1. The capital stock of this Corporation may be issued only to individuals duly licensed to practice medicine in the State of Connecticut or the personal representative or estate of a deceased or legally incompetent shareholder and shall not be issued to any other person.

2. No shareholder of the capital stock of this Corporation may sell or transfer his stock at any time to any person other than an individual licensed to practice medicine in the State of Connecticut.

3. Notwithstanding anything contained in these Bylaws to the contrary, no shareholder of the capital stock of this Corporation shall at any time enter into a voting trust or any other type of agreement which, in effect, vests in another person other than one who is licensed or otherwise legally authorized to practice medicine in the State of Connecticut the authority to exercise the voting power of any or all of his shares of the capital stock of this Corporation.

4. Every certificate for shares of stock which are subject to any restriction on transfer, whether pursuant to the Certificate of Incorporation, the Bylaws or any agreement to which the Corporation is a party, shall have the fact of the restriction noted conspicuously on the certificate and shall also set forth on the face or back either the full text of the restriction or a statement that the Corporation will furnish a copy to the holder of such certificate upon written request and without charge. Any transfer of shares of stock which is made or attempted contrary to any such restriction on transfer shall be null and void.

Approved: December 26, 1996

Amended and Restated: November 11, 2011

40287968 v5 - 080456/0034

FILING #0001680886 PG 01 OF 02 VOL B-00104
FILED 12/30/1996 01:41 PM PAGE 02789
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

CERTIFICATE OF IN

STOCK CORPORATION
Office of the Secretary of the State
30 Trinity Street / P.O. Box 150470 / Hartford, CT 06115-0470

Return confirmation of filing to:	Space for office use only
Customer I.D. #	
Name Robert J. Anthony, Esq.	
Address Brown, Rudnick, Freed & Gesmer	
City CityPlace I, 185 Asylum Street	
State Hartford, CT	
Zip Code 06103	

1. NAME OF CORPORATION:

Franklin Medical Group, P.C.

2. NATURE OF BUSINESS TO BE TRANSACTED OR PURPOSES TO BE PROMOTED OR CARRIED OUT BY THE CORPORATION:

To engage in any lawful act or activity for which corporations may be formed under the Connecticut Stock Corporation Act or after January 1, 1997 the Connecticut Business Corporation Act.

3. MINIMUM AMOUNT OF STATED CAPITAL WITH WHICH THE CORPORATION SHALL COMMENCE BUSINESS:

One Thousand (1,000) dollars. (Not less than one thousand dollars)

4. AUTHORIZED SHARE INFORMATION:

Class	Number of shares	Par value
Common	20,000	$ .01

FILING #0001680886 PG 02 OF 02 VOL B-00104
FILED 12/30/1996 01:41 PM PAGE 02790
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

5. APPOINTMENT OF STATUTORY AGENT FOR SERVI

of agent:	Business address:
obert J. Anthony, Esq.	Brown, Rudnick, Freed & Gesmer, P.C. CityPlace I, 185 Asylum Street Hartford, CT 06103
	Residence address: 1277 Deer Run Circle Cheshire, CT 06410

Acceptance of appointment

Signature of agent

6. Terms, limitations, relative rights and preferences of each class of shares and series thereof (if any) or express grant of authority to the board of directors pursuant to Section 33-341 of the Connecticut General Statutes: None

Other Provisions:

The Bylaws of the Corporation may be repealed or amended by the shareholders and such repeal or amendment of Bylaws by shareholders shall require the affirmative vote of a majority of the voting power of shares entitled to vote thereon.

Dated this 26th day of December, 1996

I/We hereby declare, under the penalties of false statement, that the statements make in the foregoing certificate are true.

Certificate must be signed by each incorporator.

NAME OF INCORPORATOR(S) (print or type)	SIGNATURE (S)
Michael Simms, M.D.	

Franklin Medical Group, P.C.
A Connecticut Stock Corporation

Shareholder(s)	Certificate No.	Shares
Michael Simms, M.D.	No. 1 - Common Stock	100 (100%)

Stock Transfer Agreement between SMH and Dr. Simms dated 12/26/96 (copy attached)

SMH has caused FMG to be incorporated; at the request of SMH, Dr. Simms has agreed to be the sole shareholder of FMG as an accommodation to SMH. Dr. Simms may not transfer or sell his shares. Dr. Simms only responsibilities are to hold the shares and elect as directors of FMG these individuals designated by SMH. SMH shall fully indemnify Dr. Simms.

Board of Directors	Term Ends
Gregory Buller, M.D.	9/30/05
Matthew Kellogg	9/30/05
Stanley Dudrick, M.D.	9/30/05
M. Alex Geertsma, M.D.	9/30/05
Peter Jacoby, M.D.	9/30/05
Michael Matzkin, D.D.S.	9/30/05
Robert P. Ritz	9/30/05
Michael Simms, M.D.	9/30/05

Officers		Term Ends
Peter Jacoby, M.D.	President	9/30/05
Gregory Buller, M.D.	Vice President	9/30/05
Michael Matzkin, D.D.S.	Secretary	9/30/05
Matthew Kellogg	Interim Treasurer	9/30/05
Michael Novak	Secretary/Administrator	9/30/05

Relevant sections of the Bylaws (copy attached):
Article IV. 1.
Directors need not be shareholders and need not be residents of Connecticut. FMG shall have not more than 8 nor less than 3 directorships.

Article IV. 5.
The directors, other than the first board of directors, shall be elected annually, at the annual meeting of the shareholders for a term extending until the next annual meeting of the shareholders; and each director shall hold office for the term for which he is elected and until his successor has been elected and qualified. Any vacancy or vacancies occurring in the board, other than a vacancy created by an increase in the number of directorships, may be filled for the unexpired term by action of the sole remaining director in the office or by the concurring vote of a majority of the remaining directors in office, though such remaining directors are less than a quorum, though the number of directors is less than a quorum, and though such majority is less than a quorum.

EXHIBIT 13a

2nd Public Notice

Ad #: RA0714893

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("Trinity Health New England") 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, Trinity Health New Englandwill become the sole corporate member of Saint Mary's Health System, inc. and the corporate organization and governance of Saint Mary's Health System will be revised to be consistent with the organizational and governance structure of Trinity Health New England subsidiaries. Also, under this proposal, ultimate control of Saint Mary's affiliated captive physician group, Franklin Medical Group, PC ("FMG"),will transfer to Trinity Health and Trinity Health New England as a result of the member substitution.FMG will remain at its current locations. There are no capital expenditures for this proposal. Saint Mary's Health System, 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.
56 Franklin Street
Waterbury, CT 06706

Franklin Medical Group, PC
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

R-A 3/31/16-4/2/16

AFFIDAVIT OF PUBLICATION

STATE OF CONNECTICUT
County of New Haven Waterbury April 6th 20 16

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

ST. MARY'S HOSPITAL

was published in said **Republican-American** in **3** editions of said newspaper issued between **03/31/16** and **04/02/16**

Judith K Ayer

SUBSCRIBED AND SWORN BEFORE ME THIS THE 6th

day of April 20 16

Susan Attard

Notary Public

My Commission Expires: 3/31/18

RepublicanAmerican

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

Classified Advertising Proof

Account Number: 75401
Order Number: RA0714893

ann ferraro
ST. MARY'S HOSPITAL
56 FRANKLIN STREET
WATERBURY, CT 06706
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Start date: 3/31/2016 | **Stop date:** 4/2/2016 |
Insertions: 3

Title: Rep-Am.com | **Class:** L-Legal -Public Notice 019
Start date: 3/31/2016 | **Stop date:** 4/2/2016 |
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("Trinity Health New England") 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, Trinity Health New Englandwill become the sole corporate member of Saint Mary's Health System, Inc. and the corporate organization and governance of Saint Mary's Health System will be revised to be consistent with the organizational and governance structure of Trinity Health New England subsidiaries. Also, under this proposal, ultimate control of Saint Mary's affiliated captive physician group, Franklin Medical Group, PC ("FMG"),will transfer to Trinity Health and Trinity Health New England as a result of the member substitution.FMG will remain at its current locations. There are no capital expenditures for this proposal. Saint Mary's Health System, 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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20555 Victor Parkway
Livonia, MI 48152

R-A 3/31/16-4/2/16

Total Order Price: $480.24

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Telephone: 203-574-3636 ext 1163 | **Fax:** 203-754-0644

Article V.1.
The officers of the Corporation shall consist of a president, secretary, treasurer. The directors may, in addition to the foregoing officers, appoint 1or more vice presidents, 1or more assistant treasurers, and 1or more assistant secretaries. Any vacancy or vacancies occurring in any office of the Corporation may be filled for the unexpired term by action of the sole remaining director in office or by the concurring vote of a majority of the remaining directors in office, though such remaining directors are less than a quorum, though the number of directors at the meeting are less than a quorum, and though such majority is less than a quorum.

Article X: Restrictions on Business Activities
The business and activities to be conducted by this Corporation shall be limited to:
1. The practice of medicine.
2. The investment of its funds in real estate, mortgages, stocks, bonds or other types of investments.
3. The owning of real or personal property incident to the conduct of the practice of medicine.

Article XI: Restrictions on Transfer of Stocks
1. The capitol stock of this Corporation may be issued only to individuals licensed to practice medicine in the State of Connecticut or the personal representative or estate of a deceased or legally incompetent shareholder and shall not be issued to any other person.
2. No shareholder of the capital stock of this Corporation may sell or transfer his stock at any time to any person other than an individual licensed to practice medicine in the State of Connecticut.

Greer, Leslie

From: Carney, Brian
Sent: Monday, May 23, 2016 12:57 PM
To: 'chartley@stfranciscare.org'
Cc: Riggott, Kaila; Greer, Leslie
Subject: 16-32077-CON Completeness Letter
Attachments: 16-32077 FMG Completeness 5_23_16.docx

Dear Mr. Hartley,

Please see attached letter requesting additional information in the above-referenced matter. Please email a response to indicate receipt of this message.

Thanks,
Brian Carney

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov
Web: 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

May 23, 2016 Via Email Only

R. Christopher Hartley,
Senior Vice President
Saint Francis Hospital and Medical Center
Hartford, CT 06105
chartley@stfranciscare.org

RE: Certificate of Need Application: Docket Number: 16-32077-CON
Transfer of Ownership of an Affiliate
Certificate of Need Completeness Letter

Dear Mr. Hartley:

On April 25, 2016, OHCA received the Certificate of Need application from Franklin Medical Group, P.C. ("FMG"), Saint Mary's Health System, Inc. ("SMHS") and Trinity Health – New England, Inc. ("TH-NE") or collectively, ("Applicants") to transfer ownership of FMG from SMHS to TH-NE.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to each of the following email addresses: OHCA@ct.gov; brian.carney@ct.gov; and kaila.riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 527** and reference "**Docket Number: 16-32077-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was

transmitted. Therefore, please provide your written responses to OHCA no later than **Friday, July 22, 2016**, otherwise your application will be automatically considered withdrawn.

1. Please revise and resubmit Table 5 on page 62 of the application to include updated utilization volumes for FY 2016. Provide the months that have been included in FY 2016 and label the type of volume represented (e.g., visits).

2. Revise and resubmit Table 6 on page 63 of the application to add utilization projections for FY 2019. Adjust all utilization projections, if necessary, to reflect the updated FY 2016 volumes provided in question one (above).

3. Revise and resubmit Table 7 on page 64 of the application to include payer mix for FY 2015-2019 for the group practice's utilization volumes, not for Saint Mary's Hospital. The totals reflected in Table 7 should match the totals submitted in Tables 5 and 6.

4. Please describe any anticipated changes to the payer mix volumes reported in response to question three.

Greer, Leslie

From: Hartley, Christopher <CHartley@stfranciscare.org>
Sent: Tuesday, May 24, 2016 8:24 AM
To: Carney, Brian
Cc: Riggott, Kaila; Greer, Leslie; Rotavera, Liz; Attorney Bob Anthony (BAnthony@Stmh.org); Capone, Claudio
Subject: RE: 16-32077-CON Completeness Letter

Thank you. We will get back to you soon.

From: Carney, Brian [mailto:Brian.Carney@ct.gov]
Sent: Monday, May 23, 2016 12:57 PM
To: Hartley, Christopher
Cc: Riggott, Kaila; Greer, Leslie
Subject: 16-32077-CON Completeness Letter

Dear Mr. Hartley,

Please see attached letter requesting additional information in the above-referenced matter. Please email a response to indicate receipt of this message.

Thanks,
Brian Carney

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov
Web: www.ct.gov/ohca

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Greer, Leslie

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Friday, May 27, 2016 10:31 AM
To: Carney, Brian; User, OHCA; Riggott, Kaila
Cc: Hartley, Christopher; Attorney Bob Anthony (BAnthony@Stmh.org)
Subject: Completeness Questions for FMG's Change in Ownership (Docket Number: 16-32077-CON)
Attachments: Docket Number 16-32077-CON Completeness Questions from 5.23.2016.pdf; Docket Number 16-32077-CON Completeness Questions from 5.23.2016.docx

Hello,

Attached are Franklin Medical Group's responses to the May 23, 2016 OHCA completeness questions in both PDF and Word file formats. Feel free to contact either Christopher Hartley or Bob Anthony cc'd herein.

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

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 Hospital and Medical Center 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 Hospital and Medical Center and its affiliated entities accepts no liability for any damage caused by any virus transmitted by this email.

Saint Mary's
HOSPITAL

May 27, 2016

Via Email

Mr. Brian Carney
Associate Research 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 Franklin Medical Group P.C., Saint Mary's Health System, Inc. and Trinity Health – New England, Inc. to A Change in the Ultimate Controlling Entity of Franklin Medical Group from Saint Mary's Health System, Inc. to Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc. DN: 16-32077-CON

Dear Mr. Carney,

Enclosed please find our responses to OHCA's May 23, 2016 letter regarding the above referenced Certificate of Need application. We are hopeful that these answers will allow us to move forward with Franklin Medical Group's joining Trinity Health – New England, Inc., formerly known as 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,

Saint Mary's Health System

By: _____
Robert Anthony
General Counsel

Trinity Health - New England, Inc.,
fka Saint Francis *Care* Inc.

By: _____
R. Christopher Hartley
Senior Vice President
Business Development &
Government Relations

Enclosures

1. **Please revise and resubmit Table 5 on page 62 of the application to include updated utilization volumes for FY2016. Provide the months that have been included in FY 2016 and label the type of volume represented (e.g., visits).**

TABLE 5
HISTORICAL UTILIZATION BY SERVICE (Visits)

Service	Actual Volume FY13	FY14	FY15	CFY Volume FY2016 (10/15-4/16)
Primary Care	52,389	46,997	105,681	77,720
Cardiology	17,812	18,985	26,736	20,582
Breast Surgeons	5,183	5,853	13,268	10,013
Surgery	5,416	9,481	12,199	9,405
Gastroenterology	3,121	5,327	15,678	10,201
Oncology/Hematology		2,496	3,328	2,399
Rheumatology			614	1,994
GYN	2,706	2,754	2,219	1,799
Sleep	3,128	3,569	3,789	2,395
Pulmonary & Critical Care	7,960	8,108	10,493	6,034
Infectious Disease	5,275	5,541	5,596	3,631
Pediatrics		4,300	12,907	8,100
Behavioral Health (IP & OP)	16,404	17,819	20,490	11,728
Academic	33,988	37,398	50,462	19,194
Hospital Based	49,321	43,216	47,346	24,703
Total	202,703	211,844	330,806	209,898

2. **Revise and resubmit Table 6 on page 63 of the application to add utilization projections for FY 2019. Adjust all utilization projections, if necessary, to reflect the updated FY 2016 volumes provided in question one (above).**

TABLE 6
PROJECTED UTILIZATION BY SERVICE (Visits)

	Projected Volume			
Service	**FY16**	**FY17**	**FY18**	**FY19**
Primary Care	138,560	145,488	152,762	160,400
Cardiology	35,283	37,048	38,900	40,845
Breast Surgeons	17,165	18,023	18,925	19,871
Surgery	16,123	16,929	17,775	18,664
Gastroenterology	17,487	18,362	19,280	20,244
Oncology/Hematology	4,113	4,318	4,534	4,761
Rheumatology	3,418	3,589	3,769	3,957
GYN	3,084	3,238	3,400	3,570
Sleep	4,106	4,311	4,527	4,753
Pulmonary & Critical Care	10,344	10,861	11,404	11,974
Infectious Disease	6,225	6,536	6,863	7,206
Pediatrics	13,886	14,580	15,309	16,074
Behavioral Health (IP & OP)	20,105	21,110	22,166	23,274
Academic	32,904	34,549	36,277	38,090
Hospital Based	42,348	44,465	46,689	49,023
Total	365,151	383,408	402,579	422,707

3. **Revise and resubmit Table 7 on page 64 of the application to include payer mix for FY 2015-2019 for the group practice's utilization volumes, not for Saint Mary's Hospital. The totals reflected in Table 7 should match the totals submitted in Tables 5 and 6.**

TABLE 7
Applicant's Current & Projected Payer Mix

Payer	FY2015		Projected							
			FY2016		FY2017		FY2018		FY2019	
	Visits	%	Visits	%	Visits	%	Visits	%	Visits	%
Medicare	130,404	39.42%	143,943	39.42%	151,139	39.42%	158,697	39.42%	166,631	39.42%
Medicaid	74,464	22.51%	82,195	22.51%	86,305	22.51%	90,621	22.51%	95,151	22.51%
Champus & TriCare	-	-	-	-	-	-	-	-	-	-
Total Government	204,868	61.93%	226,138	61.93%	237,445	61.93%	249,317	61.93%	261,782	61.93%
Commercial Insurers	121,836	36.83%	134,485	36.83%	141,209	36.83%	148,270	36.83%	155,683	36.83%
Uninsured	2,183	0.66%	2,410	0.66%	2,530	0.66%	2,657	0.66%	2,790	0.66%
Workers Comp	1,919	0.58%	2,118	0.58%	2,224	0.58%	2,335	0.58%	2,452	0.58%
Total Non-Government	125,938	38.07%	139,013	38.07%	145,963	38.07%	153,262	38.07%	160,925	38.07%
Total Payer Mix	330,806	100.00%	365,151	100.00%	383,408	100.00%	402,579	100.00%	422,707	100.00%

4. **Please describe any anticipated changes to payer mix volumes reported in response to question three.**

There are no anticipated changes to the payer mix. The Hospital payer mix was inadvertently included in the original submission of the CON. The Franklin Medical Group payer mix has been provided in Table 7 with corresponding visits (see question 3 above).

Greer, Leslie

From: Carney, Brian
Sent: Thursday, June 16, 2016 3:18 PM
To: 'chartley@stfranciscare.org'
Cc: Riggott, Kaila; Greer, Leslie
Subject: 16-32077-CON Completeness Letter (2nd)
Attachments: 16-32077 FMG 2nd Completeness 6_16_16.docx; Financial Worksheets.xlsx

Dear Mr. Hartley,

Please see attached letter requesting additional information in the above-referenced matter.

Please email a response to indicate receipt of this message.

Thanks,
Brian A. Carney

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

June 16, 2016 Via Email Only

R. Christopher Hartley,
Senior Vice President
Saint Francis Hospital and Medical Center
Hartford, CT 06105
chartley@stfranciscare.org

RE: Certificate of Need Application: Docket Number: 16-32077-CON
Transfer of Ownership of an Affiliate
Certificate of Need Completeness Letter (2nd)

Dear Mr. Hartley:

On May 27, 2016, OHCA received responses to completeness questions regarding the Certificate of Need application from Franklin Medical Group, P.C. ("FMG"), Saint Mary's Health System, Inc. ("SMHS") and Trinity Health – New England, Inc. ("TH-NE") or collectively, ("Applicants") to transfer ownership of FMG from SMHS to TH-NE.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to each of the following email addresses: OHCA@ct.gov; brian.carney@ct.gov; and kaila.riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 531** and reference "**Docket Number: 16-32077-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was

transmitted. Therefore, please provide your written responses to OHCA no later than **Monday, August 15, 2016**, otherwise your application will be automatically considered withdrawn.

1. Page 45 of the application describes cost savings attributable to group purchasing and reduced administrative costs related to the recruitment of new providers, following the integration of FMG into TH-NE. Please revise and resubmit Financial Worksheet (B), found on pages 376-377 of the application, to include all estimated cost savings incremental to the proposal. Include FYs 2015-2019 and provide all assumptions.

2. Financial Worksheet (A) Trinity Health–New England, Inc., submitted on page 441-442 of Docket No. 15-32045-CON, provides incremental projections associated with the acquisition of SMHS by TH-NE. Please verify that these incremental projections account for FMG and its projected $17M dollar annual loss from operations. If not, please revise and resubmit Financial Worksheet (A) for Trinity Health–New England, Inc., include FYs 2015-2019 and provide all assumptions.

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**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue				$0			$0			$0			$0
2	Less: Allowances				$0			$0			$0			$0
3	Less: Charity Care				$0			$0			$0			$0
4	Less: Other Deductions				$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare				$0			$0			$0			$0
6	Medicaid				$0			$0			$0			$0
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers				$0			$0			$0			$0
10	Uninsured				$0			$0			$0			$0
11	Self Pay				$0			$0			$0			$0
12	Workers Compensation				$0			$0			$0			$0
13	Other				$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts				**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue				**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions				**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages				$0			$0			$0			$0
2	Fringe Benefits				$0			$0			$0			$0
3	Physicians Fees				$0			$0			$0			$0
4	Supplies and Drugs				$0			$0			$0			$0
5	Depreciation and Amortization				$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]				$0			$0			$0			$0
7	Interest Expense				$0			$0			$0			$0
8	Malpractice Insurance Cost				$0			$0			$0			$0
9	Lease Expense				$0			$0			$0			$0
10	Other Operating Expenses				$0			$0			$0			$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING REVENUE				**$0**			**$0**			**$0**			**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

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**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	Principal Payments				**$0**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
D.	**FTEs**				**0**			**0**			**0**			**0**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges				**0**			**0**			**0**			**0**
2	Outpatient Visits				**0**			**0**			**0**			**0**
	TOTAL VOLUME	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide 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.

FOR-PROFIT

Applicant Name:

Financial Worksheet (B)

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$0	$0	$0	$0			$0			$0			$0
2	Less: Allowances	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$0	$0	$0	$0			$0			$0			$0
7	CHAMPUS & TriCare	$0	$0	$0	$0			$0			$0			$0
8	Other	$0	$0	$0	$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers	$0	$0	$0	$0			$0			$0			$0
10	Uninsured	$0	$0	$0	$0			$0			$0			$0
11	Self Pay	$0	$0	$0	$0			$0			$0			$0
12	Workers Compensation	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$0	$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$0	$0	$0	$0			$0			$0			$0
2	Fringe Benefits	$0	$0	$0	$0			$0			$0			$0
3	Physicians Fees	$0	$0	$0	$0			$0			$0			$0
4	Supplies and Drugs	$0	$0	$0	$0			$0			$0			$0
5	Depreciation and Amortization	$0	$0	$0	$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0			$0			$0			$0
7	Interest Expense	$0	$0	$0	$0			$0			$0			$0
8	Malpractice Insurance Cost	$0	$0	$0	$0			$0			$0			$0
9	Lease Expense	$0	$0	$0	$0			$0			$0			$0
10	Other Operating Expenses	$0	$0	$0	$0			$0			$0			$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME/(LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

FOR-PROFIT

Applicant Name:

Financial Worksheet (B)

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**
	NET INCOME	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
E.	**FTEs**	**0**	**0**	**0**	**0**			**0**			**0**			**0**
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges	0	0	0	**0**			**0**			**0**			**0**
2	Outpatient Visits	0	0	0	**0**			**0**			**0**			**0**
	TOTAL VOLUME	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

FINANCIAL WORKSHEET DESCRIPTIONS

Financial Worsheet:

C– Sale of Non-Profit Hospital to For-Profit Entity

Cells Legend:

	Indicates input cell
	Indicates calculated cell

Columns 1,2,5,8 & 11: **Add Non-Profit data (without CON)**

Columns 3,4,6,7,9,10,12 & 13: **Add For-Profit data (with CON & incremental to CON)**

Sale of Non-Profit Hosptal to For-Profit Entity

Name Entity:

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue				$0			$0			$0			$0
2	Less: Allowances				$0			$0			$0			$0
3	Less: Charity Care				$0			$0			$0			$0
4	Less: Other Deductions				$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare				$0			$0			$0			$0
6	Medicaid				$0			$0			$0			$0
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
9	Commercial Insurers				$0			$0			$0			$0
10	Uninsured				$0			$0			$0			$0
11	Self Pay				$0			$0			$0			$0
12	Workers Compensation				$0			$0			$0			$0
13	Other				$0			$0			$0			$0
	Total Non-Government	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
14	Less: Provision for Bad Debts				**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
15	Other Operating Revenue				**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions				**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages				$0			$0			$0			$0
2	Fringe Benefits				$0			$0			$0			$0
3	Physicians Fees				$0			$0			$0			$0
4	Supplies and Drugs				$0			$0			$0			$0
5	Depreciation and Amortization				$0			$0			$0			$0
6	Provision for Bad Debts-Other[b]				$0			$0			$0			$0
7	Interest Expense				$0			$0			$0			$0
8	Malpractice Insurance Cost				$0			$0			$0			$0
9	Lease Expense				$0			$0			$0			$0
10	Other Operating Expenses				$0			$0			$0			$0
	TOTAL OPERATING EXPENSES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Provision for Income Taxes[c]				**$0**			**$0**			**$0**			**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	INCOME / (LOSS) FROM OPERATIONS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Sale of Non-Profit Hosptal to For-Profit Entity

Name Entity:

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**	**FY**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	NON-OPERATING INCOME / REVENUE				$0			$0			$0			$0
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
C.	**Retained Earnings/ Net Assets, beginning of year**				$0			$0			$0			$0
	Retained Earnings / Net Assets, end of year				$0			$0			$0			$0
	Principal Payments				$0			$0			$0			$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
E.	**FTEs**				0			0			0			0
F.	**VOLUME STATISTICS[d]**													
1	Inpatient Discharges				0			0			0			0
2	Outpatient Visits				0			0			0			0
	TOTAL VOLUME	0	0	0	0	0	0	0	0	0	0	0	0	0

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Capone, Claudio <Claudio.Capone@TrinityHealth-NE.org>
Sent: Friday, June 24, 2016 1:24 PM
To: User, OHCA; Carney, Brian; Riggott, Kaila
Cc: Joe Connolly; Attorney Bob Anthony; Hartley, Christopher
Subject: 16-32077-CON Completeness Letter Answers
Attachments: Completeness Responses 6.16.2016 for Docket Number 16_32077_CON.pdf; Docket Number 16-32077-CON Completeness Questions from 6.16.2016.docx; FMG Financial_workbook_-updated 6.22.16.xlsx

Hello…Attached are both Word and PDF versions of the Franklin Medical Group's responses to the completeness letter from June 16, 2016.

Please contact either Christopher Hartley or Attorney Bob Anthony if you have any further questions.

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

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 Hospital and Medical Center 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 Hospital and Medical Center and its affiliated entities accepts no liability for any damage caused by any virus transmitted by this email.

Saint Mary's
HOSPITAL

June 24, 2016

Via Email

Mr. Brian Carney
Associate Research 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 Franklin Medical Group P.C., Saint Mary's Health System, Inc. and Trinity Health – New England, Inc. to A Change in the Ultimate Controlling Entity of Franklin Medical Group from Saint Mary's Health System, Inc. to Trinity Health – New England, Inc., formerly known as Saint Francis *Care*, Inc. DN: 16-32077-CON

Dear Mr. Carney,

Enclosed please find our responses to OHCA's June 16, 2016 letter regarding the above referenced Certificate of Need application. We are hopeful that these answers will allow us to move forward with Franklin Medical Group's joining Trinity Health – New England, Inc., formerly known as 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,

Saint Mary's Health System

By: Robert Anthony, Esq. af
Robert Anthony
General Counsel

Trinity Health - New England, Inc.,
fka Saint Francis *Care* Inc.

By: Chris Hartley
R. Christopher Hartley
Senior Vice President
Business Development & Government Relations

1. **Page 45 of the application describes cost savings attributable to group purchasing and reduced administrative costs related to the recruitment of new providers, following the integration of FMG into TH-NE. Please revise and resubmit Financial Worksheet (B), found on pages 376-377 of the application, to include all estimated cost savings incremental to the proposal. Include FYs 2015-2019 and provide all assumptions.**

   As noted on page 45, cost savings related to these items are anticipated, however, it is premature to quantify such amounts. Once the transaction is approved, additional analysis with respect to pricing and staffing models will be evaluated. The budget as submitted is conservative.

2. **Financial Worksheet (A) Trinity Health–New England, Inc., submitted on page 441-442 of Docket No. 15-32045-CON, provides incremental projections associated with the acquisition of SMHS by TH-NE. Please verify that these incremental projections account for FMG and its projected $17M dollar annual loss from operations. If not, please revise and resubmit Financial Worksheet (A) for Trinity Health–New England, Inc., include FYs 2015-2019 and provide all assumptions.**

   Trinity Health – NE Financial Worksheet (A) includes Saint Mary's Health System, Inc. as incremental to the project. Since the projection for Saint Mary's Health System, Inc. Financial Worksheet (A) didn't change, which includes Franklin, then there is no change for Trinity Health – NE Financial Worksheet (A).

FOR-PROFIT

Franklin Medical Group, P.C.

Financial Worksheet (B)

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY15**	**FY16**	**FY**	**FY16**	**FY17**	**FY**	**FY17**	**FY18**	**FY**	**FY18**	**FY19**	**FY**	**FY19**
		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	$64,215	$82,743	$0	$82,743	$86,880		$86,880	$91,224		$91,224	$95,785		$95,785
2	Less: Allowances	$36,599	$47,515	$0	$47,515	$50,413		$50,413	$53,489		$53,489	$56,751		$56,751
3	Less: Charity Care	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
4	Less: Other Deductions	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue	**$27,616**	**$35,228**	**$0**	**$35,228**	**$36,467**	**$0**	**$36,467**	**$37,736**	**$0**	**$37,736**	**$39,034**	**$0**	**$39,034**
5	Medicare	$7,501	$9,568	$0	$9,568	$9,904		$9,904	$10,249		$10,249	$10,602		$10,602
6	Medicaid	$5,670	$7,232	$0	$7,232	$7,487		$7,487	$7,747		$7,747	$8,014		$8,014
7	CHAMPUS & TriCare	$55	$70	$0	$70	$73		$73	$75		$75	$78		$78
8	Other	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
	Total Government	**$13,225**	**$16,871**	**$0**	**$16,871**	**$17,464**	**$0**	**$17,464**	**$18,072**	**$0**	**$18,072**	**$18,693**	**$0**	**$18,693**
9	Commercial Insurers	$13,896	$17,727	$0	$17,727	$18,350		$18,350	$18,989		$18,989	$19,642		$19,642
10	Uninsured	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$196	$250	$0	$250	$259		$259	$268		$268	$277		$277
12	Workers Compensation	$229	$292	$0	$292	$303		$303	$313		$313	$324		$324
13	Other	$69	$88	$0	$88	$91		$91	$94		$94	$98		$98
	Total Non-Government	**$14,391**	**$18,357**	**$0**	**$18,357**	**$19,003**	**$0**	**$19,003**	**$19,664**	**$0**	**$19,664**	**$20,341**	**$0**	**$20,341**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$27,616**	**$35,228**	**$0**	**$35,228**	**$36,467**	**$0**	**$36,467**	**$37,736**	**$0**	**$37,736**	**$39,034**	**$0**	**$39,034**
14	Less: Provision for Bad Debts	$1,495	$1,477	$0	**$1,477**	$1,551		**$1,551**	$1,628		**$1,628**	$1,710		**$1,710**
	Net Patient Service Revenue less provision for bad debts	**$26,121**	**$33,751**	**$0**	**$33,751**	**$34,916**	**$0**	**$34,916**	**$36,107**	**$0**	**$36,107**	**$37,324**	**$0**	**$37,324**
15	Other Operating Revenue	$4,162	$3,725	$0	**$3,725**	$3,800		**$3,800**	$3,800		**$3,800**	$3,800		**$3,800**
17	Net Assets Released from Restrictions	$0	$0	$0	**$0**	$0		**$0**	$0		**$0**	$0		**$0**
	TOTAL OPERATING REVENUE	**$30,283**	**$37,476**	**$0**	**$37,476**	**$38,716**	**$0**	**$38,716**	**$39,907**	**$0**	**$39,907**	**$41,124**	**$0**	**$41,124**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$32,716	$38,677	$0	$38,677	$39,644		$39,644	$40,635		$40,635	$41,651		$41,651
2	Fringe Benefits	$4,371	$4,794	$0	$4,794	$4,914		$4,914	$5,037		$5,037	$5,163		$5,163
3	Physicians Fees	$1,022	$949	$0	$949	$977		$977	$1,007		$1,007	$1,037		$1,037
4	Supplies and Drugs	$1,567	$1,586	$0	$1,586	$1,587		$1,587	$1,666		$1,666	$1,750		$1,750
5	Depreciation and Amortization	$306	$295	$0	$295	$304		$304	$313		$313	$322		$322
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$816	$1,274	$0	$1,274	$1,299		$1,299	$1,325		$1,325	$1,352		$1,352
9	Lease Expense	$2,046	$2,318	$0	$2,318	$2,364		$2,364	$2,412		$2,412	$2,460		$2,460
10	Other Operating Expenses	$4,252	$4,779	$0	$4,779	$4,875		$4,875	$4,972		$4,972	$5,072		$5,072
	TOTAL OPERATING EXPENSES	**$47,096**	**$54,672**	**$0**	**$54,672**	**$55,965**	**$0**	**$55,965**	**$57,367**	**$0**	**$57,367**	**$58,806**	**$0**	**$58,806**
	INCOME/(LOSS) FROM OPERATIONS	**($16,813)**	**($17,196)**	**$0**	**($17,196)**	**($17,249)**	**$0**	**($17,249)**	**($17,460)**	**$0**	**($17,460)**	**($17,682)**	**$0**	**($17,682)**
	NON-OPERATING INCOME	**($8)**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Income before provision for income taxes	**($16,821)**	**($17,196)**	**$0**	**($17,196)**	**($17,249)**	**$0**	**($17,249)**	**($17,460)**	**$0**	**($17,460)**	**($17,682)**	**$0**	**($17,682)**
	Provision for income taxes[c]	**$0**	$0	$0	**$0**			**$0**			**$0**			**$0**

FOR-PROFIT

Franklin Medical Group, P.C.

Financial Worksheet (B)

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	**Total Entity:**	**FY15**	**FY16**	**FY**	**FY16**	**FY17**	**FY**	**FY17**	**FY18**	**FY**	**FY18**	**FY19**	**FY**	**FY19**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	NET INCOME	**($16,821)**	**($17,196)**	**$0**	**($17,196)**	**($17,249)**	**$0**	**($17,249)**	**($17,460)**	**$0**	**($17,460)**	**($17,682)**	**$0**	**($17,682)**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**-55.5%**	**-45.9%**	**0.0%**	**-45.9%**	**-44.6%**	**0.0%**	**-44.6%**	**-43.8%**	**0.0%**	**-43.8%**	**-43.0%**	**0.0%**	**-43.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-55.6%**	**-45.9%**	**0.0%**	**-45.9%**	**-44.6%**	**0.0%**	**-44.6%**	**-43.8%**	**0.0%**	**-43.8%**	**-43.0%**	**0.0%**	**-43.0%**
E.	**FTEs**	**0**	**0**	**0**	**0**			**0**			**0**			**0**
F.	**VOLUME STATISTICS[d]**													
1	wRVUs	398,786	488,339	0	**488,339**	512,756		**512,756**	538,394		**538,394**	565,313		**565,313**
2	Total Visits	330,811	365,151	0	**365,151**	383,408		**383,408**	402,579		**402,579**	422,707		**422,707**
	TOTAL VOLUME	**729,597**	**853,490**	**0**	**853,490**	**896,164**	**0**	**896,164**	**940,973**	**0**	**940,973**	**988,020**	**0**	**988,020**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Carney, Brian
Sent: Monday, July 18, 2016 12:40 PM
To: 'chartley@stfranciscare.org'
Cc: Riggott, Kaila; Greer, Leslie
Subject: 16-32077-CON Deemed Complete
Attachments: 16-32077-CON DEEMED COMPLETE_201607181238.pdf

Dear Mr. Hartley,

Please see attached letter deeming complete the above referenced application.

Please reply to confirm receipt of this email.

Sincerely,
Brian A. Carney

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov
Web: 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

Via Email Only

July 18, 2016

R. Christopher Hartley,
Senior Vice President
Saint Francis Hospital and Medical Center
Hartford, CT 06105
chartley@stfranciscare.org

RE: Certificate of Need Application: Docket Number: 16-32077-CON
Transfer of Ownership of an Affiliate
Certificate of Need Completeness Letter

Dear Mr. Hartley:

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 July 18, 2016.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7014.

Sincerely,

Brian A. Carney

Brian A. Carney
Associate Research Analyst

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: Wednesday, July 27, 2016 1:17 PM
To: 'chartley@stfranciscare.org'
Cc: Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: DN: 16-32077-CON Final Decision
Attachments: 32077_201607271313.pdf

Tracking:

Recipient	Delivery
'chartley@stfranciscare.org'	
Carney, Brian	Delivered: 7/27/2016 1:17 PM
Riggott, Kaila	Delivered: 7/27/2016 1:17 PM
Hansted, Kevin	Delivered: 7/27/2016 1:17 PM
Martone, Kim	Delivered: 7/27/2016 1:17 PM
Olejarz, Barbara	Delivered: 7/27/2016 1:17 PM

Mr. Hartley,
Attached is the final decision for Franklin Medical Group, P.C., Saint Mary's Health System, Inc. and Trinity Health-New England, Inc.'s Certificate of Need application.

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

Subject: FW: 15-32045 - CON Saint Marys / Trinty
Attachments: 32077_201607271313.pdf

From: Martone, Kim
Sent: Wednesday, July 27, 2016 1:26 PM
To: 'Attorney Bob Anthony'
Cc: 'Chartley@stfranciscare.org'
Subject: RE: 15-32045 - CON Saint Marys / Trinty

Bob, I am attaching the signed decision for FMG.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Final Decision

Applicants: **Franklin Medical Group, P.C.**
56 Franklin Street, Waterbury, CT 06706

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: **16-32077-CON**

Project Title: **Transfer of Ownership of an Affiliate**

Project Description: Franklin Medical Group, P.C. ("FMG"), Saint Mary's Health System ("SMHS"), Trinity Health Corporation ("THC") and Trinity Health-New England, Inc., regional health ministry ("TH-NE"), collectively the ("Applicants") seek authorization to transfer ownership of FMG from SMHS to TH-NE, with no associated capital expenditure.

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 March 24, 2016, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project. However, the application was submitted outside the statutory required 90-day window following public notice. As a result, OHCA requested that the Applicants re-notice the proposal and resubmit the application. The second notice appeared in *The Republican American* (Waterbury) on March 31, April 1 and 2, 2016 and the application was re-opened effective April 25, 2016. The application was deemed complete on July 18, 2016. OHCA received no responses from the public concerning the proposal and no hearing requests were received per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.

Findings of Fact and Conclusions of Law

1. FMG is a multispecialty group that employs approximately 90 providers at various locations in and around Waterbury. Ex. A, p. 15

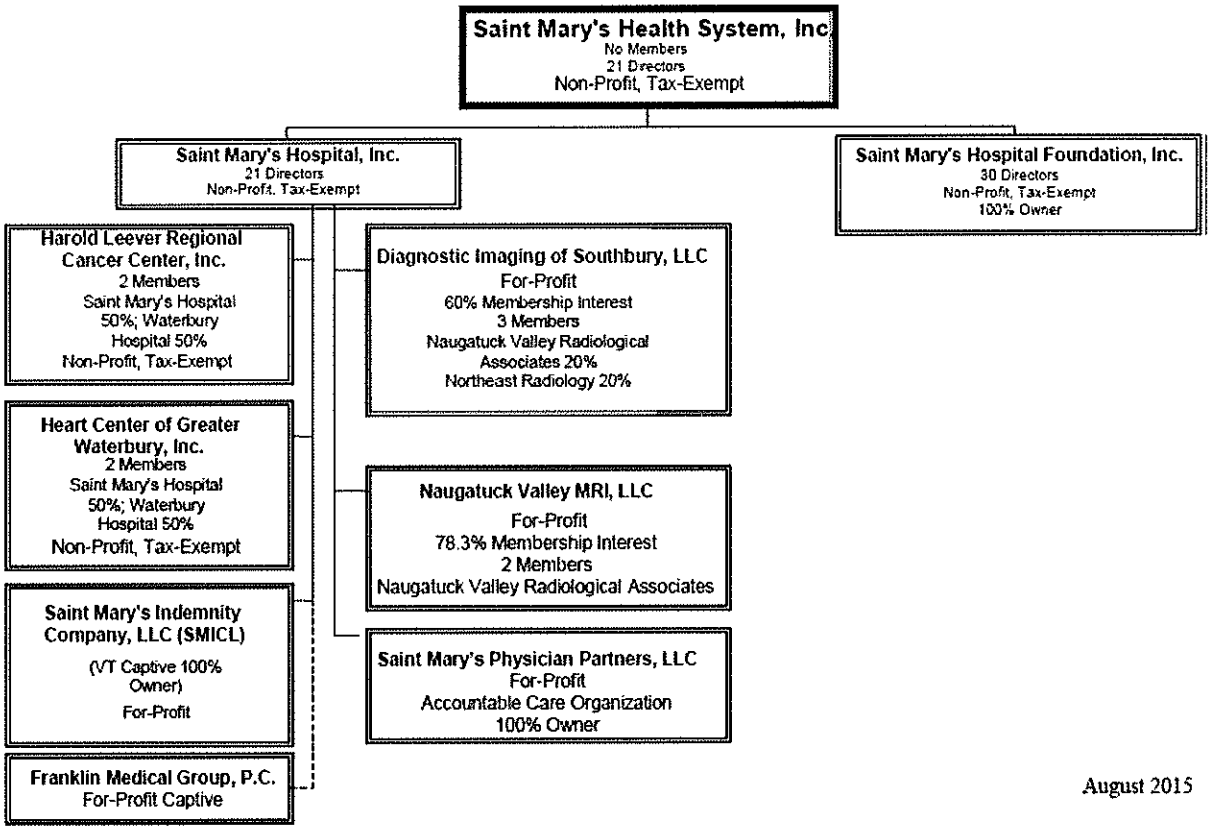
2. FMG is a for-profit affiliate of Saint Mary's Hospital ("SMH") with a separate management structure and tax ID. Ex. A, pp. 15, 505

3. 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. Docket 15-32045-CON, Ex. A, p. 19

4. TH-NE is regional health care provider and the parent company of numerous health care facilities in Connecticut, including Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford. Ex. A, p. 16

5. SMHS, which includes Saint Mary's Hospital, is an integrated Catholic health care delivery system serving Waterbury and its surrounding towns. Ex. A, p. 15

6. SMHS is the sole member of SMH and the ultimate controlling entity of FMG (see organization chart below):

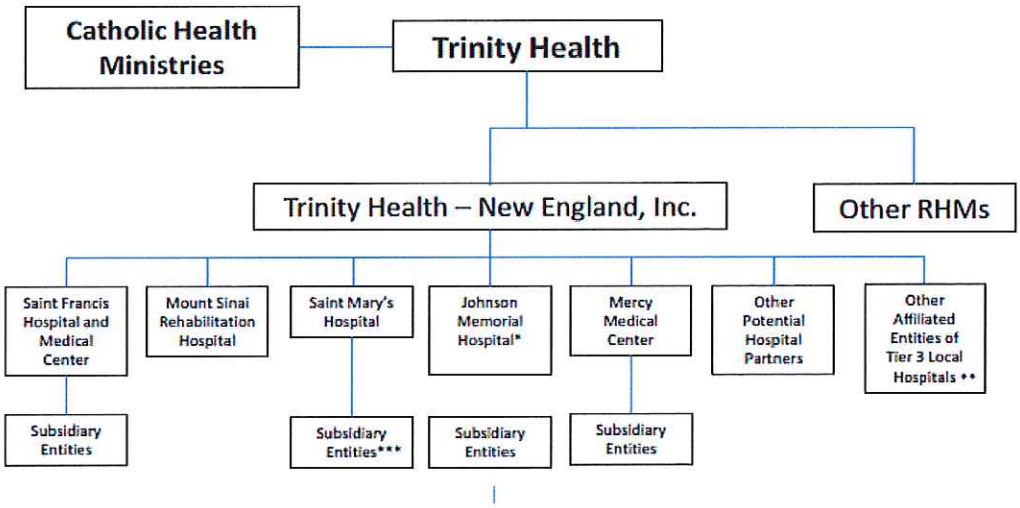


Ex. A, pp.16, 188

7. This proposal requests an organizational change to the governance structure/controlling entity of FMG from SMHS to TH-NE. Ex. A, p.17

8. As submitted in OHCA Docket 15-32045-CON and in accordance with a transfer agreement, TH-NE will become the sole corporate member of Saint Mary's Hospital, Inc. It is anticipated that SMHS will be dissolved, leaving SMH as the surviving entity. Docket 15-32045-CON, p. 16

9. Following adoption of the proposal, FMG will continue to operate as an affiliate of SMH.



*(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.

***Franklin Medical Group. P.C. would be included as a subsidiary entity of Saint Mary's Hospital upon approvals.

Ex. A, pp. 17, 85

10. FMG offers a comprehensive range of clinical services[1] in various service locations (Middlebury, Naugatuck, Prospect, Southbury Waterbury, Watertown and Wolcott). FMG does not anticipate any changes to existing services or their locations as a result of the proposal. Ex. A, pp. 36-37

[1]FMG services include, but are not limited to: breast surgery, colorectal surgery, critical care medicine, endocrinology, gastroenterology, general surgery, internal medicine, medical cardiology, medical oncology, pediatrics, primary care, psychiatry, pulmonology and rheumatology.

11. FMG's historical utilization by service is listed in the table below:

TABLE 1
FMG HISTORICAL UTILIZATION

	Actual Volume (Last 3 Completed FYs)			CFY Volume
Service	**FY 2013**	**FY 2014**	**FY 2015[1]**	**FY 2016[2]**
Primary Care	52,389	46,997	105,681	110,965
Cardiology	17,812	18,985	26,736	28,073
Breast Surgeons	5,183	5,853	13,268	13,931
Surgery	5,416	9,481	12,199	12,809
Gastroenterology	3,121	5,327	15,678	16,462
Oncology/Hematology	-	2,496	3,328	3,494
Rheumatology	-	-	614	645
GYN	2,706	2,754	2,219	2,330
Sleep	3,128	3,569	3,789	3,978
Pulmonary & Critical Care	7,960	8,108	10,493	11,018
Infectious Disease	5,275	5,541	5,596	5,876
Pediatrics	-	4,300	12,907	13,552
Behavioral Health (IP & OP)	16,404	17,819	20,490	21,515
Academic	33,988	37,398	50,462	52,985
Hospital Based	49,321	43,216	47,346	49,713
Total	**202,703**	**211,844**	**330,806**	**347,346**

[1] Volume increase due to an increase in community-based providers joining the group and the addition of two new cardiologists.
[2] FY 2016 annualized based on 7 months (October 2015 through April 2016)

Ex. A, p. 55; Ex, p. 528

12. FMG projects that patient volume will grow by approximately 5% as new providers continue to fill their patient panels.

TABLE 2
FMG PROJECTED UTILIZATION

	Projected Volume		
Service	**FY2017**	**FY2018**	**FY2019**
Primary Care	145,488	152,762	160,400
Cardiology	37,476	38,900	40,845
Breast Surgeons	18,023	18,925	19,871
Surgery	16,929	17,775	18,664
Gastroenterology	18,362	19,280	20,244
Oncology/Hematology	4,318	4,534	4,761
Rheumatology	3,589	3,769	3,957
GYN	3,238	3,400	3,570
Sleep	4,311	4,527	4,753
Pulmonary & Critical Care	10,861	11,404	11,974
Infectious Disease	6,536	6,863	7,206
Pediatrics	14,580	15,309	16,074
Behavioral Health (IP & OP)	21,110	22,166	23,274
Academic	34,549	36,277	38,090
Hospital Based	44,465	46,689	49,023
Total	383,408	402,579	422,707

Ex. A, p. 55; Ex. E, p. 528

13. The proposal will not result in any change to the patient population served, clinical services offered, service locations or physician referral patterns. Ex. A, pp. 17-18, 35, 56

14. TH-NE has committed $100M for capital needs in the first five years following the transfer (additional capital may be made available based on performance). The committed capital will be available to support SMHS and its related entities (FMG) for the strategic growth and infrastructure needed to develop an integrated delivery system, to expand and upgrade health care facilities, equipment and services and to support community health/population management initiatives and physician network development. Ex. A, p. 17

15. As a result of this proposal, FMG will gain access to Trinity Health's Unified Clinical Organization ("UCO"). The UCO allows physicians to work collaboratively to share best practices and to develop evidence-based clinical methods to promote the highest quality, safest and most effective care to patients, achieving a number of safety accomplishments (e.g., reduced sepsis mortality rate from 15.8% to 11.1% between FY 2010 and December 2014). Ex. A, pp. 42-43

16. TH-NE will provide SMHS with the necessary capital to improve its technology through the development of a health information technology exchange ("HITE") and electronic health records ("EHRs"). As a result, paper records used in some of the FMG locations will be replaced by EHRs to report patient diagnostic data. Ex. A, p. 30

17. Through its enhanced ability to efficiently share data, FMG will be able to benchmark its clinical and financial performance with the entire Trinity Health system, as well as evaluate patient satisfaction through the use of the Press Ganey survey tool. Ex. A, p. 30

18. TH-NE will assist SMHS's physicians by sharing health delivery protocol and system changes identified by the Connecticut Institute for Primary Care Innovation[2] and help introduce new technology and practice approaches that have been tested in the Innovation + Learning Center.[3] Ex. A, p. 30

19. The Applicants do not anticipate any changes to the payer mix as a result of this proposal. Medicaid patients account for 22.5% of the patient population.

TABLE 3
CURRENT & PROJECTED PAYER MIX

Payer	FY 2015		Projected							
			FY 2016		FY 2017		FY 2018		FY 2019	
	Visits	%	Visits	%	Visits	%	Visits	%	Visits	%
Medicare*	130,404	39.4%	143,943	39.4%	151,139	39.4%	158,697	39.4%	166,631	39.4%
Medicaid*	74,464	22.5%	82,195	22.5%	86,305	22.5%	90,621	22.5%	95,151	22.5%
CHAMPUS & TriCare	-	-	-	-	-	-	-	-	-	-
Total Government	**204,868**	**61.9%**	**226,138**	**61.9%**	**237,445**	**61.9%**	**249,317**	**61.9%**	**261,782**	**61.9%**
Commercial Insurers	121,836	36.8%	134,485	36.8%	141,209	36.8%	148,270	36.8%	155,683	36.8%
Uninsured	2,183	0.7%	2,410	0.7%	2,530	0.7%	2,657	0.7%	2,790	0.7%
Workers Compensation	1,919	0.6%	2,118	0.6%	2,224	0.6%	2,335	0.6%	2,452	0.6%
Total Non-Government	**125,938**	**38.1%**	**139,013**	**38.1%**	**145,963**	**38.1%**	**153,262**	**38.1%**	**160,925**	**38.1%**
Total Payer Mix	**330,806**	**100%**	**365,151**	**100%**	**383,408**	**100%**	**402,579**	**100%**	**422,707**	**100%**

*Includes managed care activity
Ex. C, p.530

[2] The Connecticut Institute for Primary Care Innovation (CIPCI) is a collaborative enterprise between Saint Francis Hospital and Medical Center and the UCONN School of Medicine. Started in November 2010, CIPCI convenes primary care stakeholders and leaders to showcase innovative practice models and serves as a resource for primary care leadership, education and research.
[3] The Innovation+Learning Center at Saint Francis Hospital and Medical Center is a 1,141 square foot, high fidelity simulation studio that includes three patient bays, a production/recording room, and three large adjacent conference rooms for debriefing teams following a simulation exercise. The patient bays can be adjusted to replicate any clinical setting (e.g., Intensive Care Unit, primary care office, etc.) to aide in training health care professionals.

20. There are no planned changes in the price structure at FMG as a result of the ownership change. Ex. A, p. 46

21. FMG has adopted SMHS's charity care policy and will continue to have self-pay and financial assistance policies following the change of ownership to TH-NE. Ex. A, pp. 46, 52

22. Operational losses are projected for FMG in each fiscal year from FY 2016 through FY 2019.

TABLE 4
FMG PROJECTED GAIN/ (LOSS) FROM OPERATIONS (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Revenue from Operations	$37,476	$38,716	$39,907	$41,124
Total Operating Expenses	$54,672	$55,965	$57,367	$58,806
Loss from Operations	**($17,196)**	**($17,249)**	**($17,460)**	**($17,682)**

Ex. E, p. 532

23. Despite the losses projected for FMG, TH-NE projects operational gains of $5.2M, $19.7M $24.8M and $26.9M, respectively, from FY 2016 through FY 2019. OHCA Docket No. 15-32045-CON, p. 441

24. 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))

25. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

26. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

27. The Applicants have demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

28. 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))

29. The Applicants have shown that there would be no 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))

30. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

31. The Applicants' historical provision of treatment in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

32. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

33. 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))

34. The Applicants have demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11))

35. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or access 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).*

FMG is a for-profit multispecialty group and affiliate of SMH that employs approximately 90 providers at various service locations in and around Waterbury. *FF1-FF2* As submitted in OHCA Docket 15-32045-CON and in accordance with a transfer agreement, TH-NE will become the sole corporate member of SMHS, the parent of SMH/FMG. This proposal requests approval for a change in the governance structure/controlling entity of FMG from SMHS to TH-NE. Following adoption of the proposal, it is anticipated that SMHS will be dissolved, SMH will remain as the surviving entity and FMG will continue to operate as an SMH affiliate. *FF6-FF9*

FMG will gain access to and benefit from Trinity Health's Unified Clinical Organization ("UCO"). The UCO allows physicians to work collaboratively to share best practices and to develop evidence-based clinical methods to promote the highest quality, safest and most effective care to patients.*FF15* TH-NE will provide SMH/FMG will the necessary capital to improve its technology through the development of HITE and EHRs. As a result, paper records used in some of the FMG locations will be replaced by EHRs to report patient diagnostic data. Through its enhanced ability to efficiently share data, FMG will be able to benchmark its clinical and financial performance with the entire THC system, as well as evaluate patient satisfaction through the use of the Press Ganey survey tool. *FF16-FF17*

FMG offers hospital and community-based services, providing more than 330,000 patient visits in FY 2015. *FF10-11* The proposal will not result in any change to the patient population served, clinical services offered, service locations or physician referral patterns. *FF13* FMG has adopted SMHS's charity care policy and will continue to provide self-pay and financial assistance policies following the change in ownership. *FF21* As a result of these combined factors, the Applicants have satisfactorily demonstrated that quality and access to cost effective physician/provider services in the region will be maintained for all relevant patient populations.

FMG projects operational losses of approximately $17M per year, with or without the proposal. Despite these losses, TH-NE still projects operational gains of $5.2M, $19.7M and $24.8M and $26.9M, respectively, from FY 2016 through FY 2019. *FF22-23* Therefore, the Applicants have satisfactorily demonstrated that the proposal is financially feasible.

Overall, the continued operation of FMG will support the financial strength of the health care system in Connecticut while ensuring that access to quality care is maintained for the population currently being served, including the Medicaid population. Accordingly, the Applicants have demonstrated that their proposal is consistent with the Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application for the transfer of SMHS's ownership interest in FMG to TH-NE, with no associated capital expenditure is hereby APPROVED.

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