Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicants:	Eastern Connecticut Health Network, Inc. 71 Haynes Street Manchester, CT 06040 Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard Suite 400 Los Angeles, CA 90025
Docket Number:	15-32016-486
Project Title:	Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Procedural History: On July 16, 2015, the Applicants filed with the Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG") the Certificate of Need ("CON") Determination Letter proposing the transfer of assets of Eastern Connecticut Health Network, Inc. and affiliates ("ECHN") to Prospect Medical Holdings, Inc. ("PMH"). The Applicants filed the application for the proposal on October 13, 2015. On January 13, 2016, OHCA and the OAG deemed the application complete, and on January 21, 2016 OHCA and the OAG jointly published a Summary of the proposal in the *Journal Inquirer.*

On February 19, 2016, OHCA and the OAG notified the Applicants of the date, time and place of the public hearing. On March 10, 2016, OHCA and the OAG notified the Applicants of the revised date, time and place of the public hearing. On March 11, 2016, a notice to the public announcing the hearing was published in the *Journal Inquirer*. Thereafter, pursuant to Conn. Gen. Stat. §19a-639a and §19a-486, a public hearing regarding this application was held on March 29 and 30, 2016, jointly by OHCA and the OAG.

Attorney Kevin T. Hansted was designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedures Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. §19a-639a(f).

The Hearing Officer heard testimony from witnesses for the Applicants and, in rendering this decision, considered the entire record of the proceeding.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc. v. S & H Computer Systems, Inc.*, 605 F. Supp. 816 (Md. Tenn. 1985).

Findings of Fact

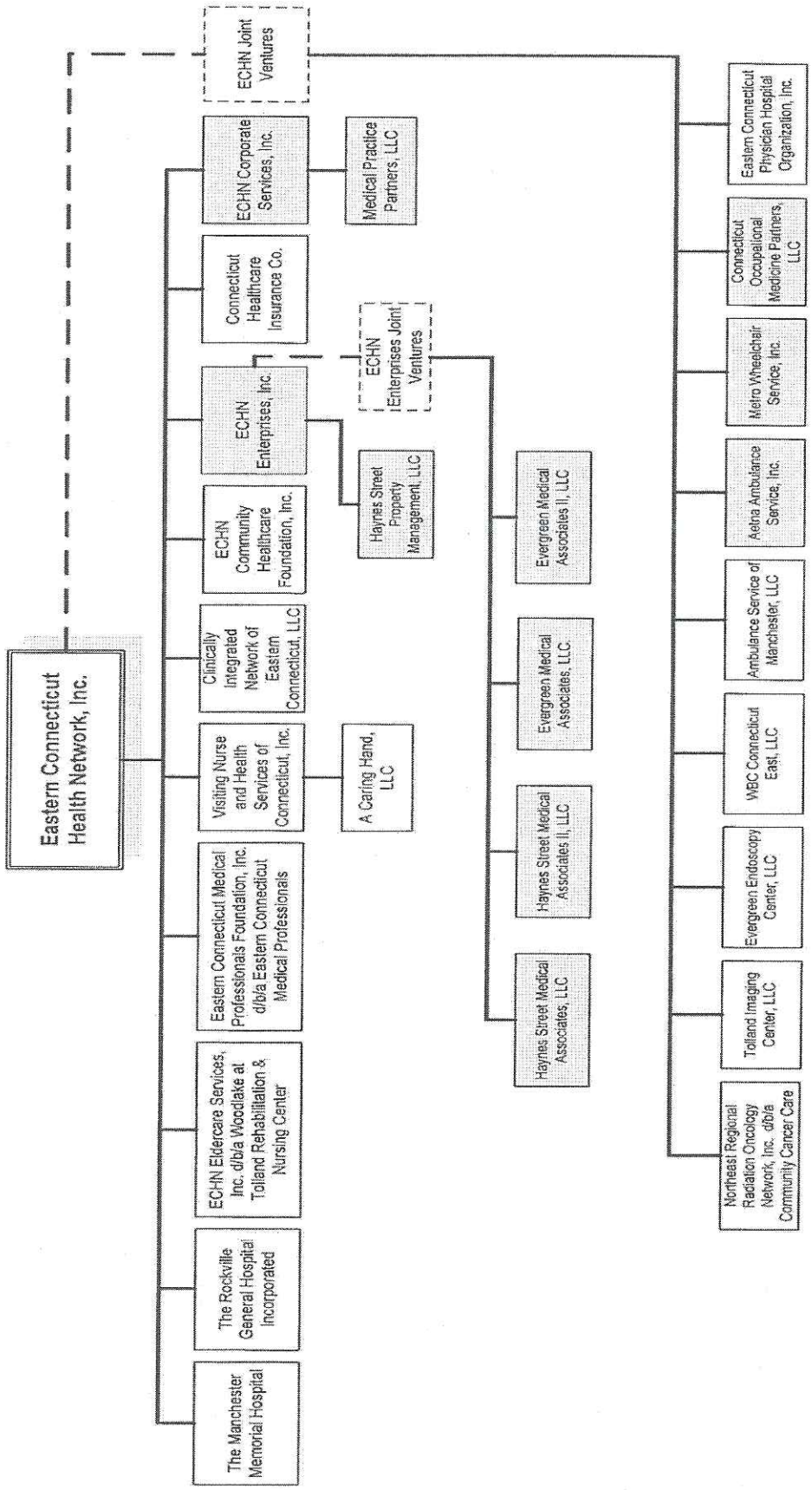
1. ECHN is a not-for-profit health care system that is the parent company of two acute care hospitals in Connecticut, Manchester Memorial Hospital ("MMH") located in Manchester and Rockville General Hospital ("RGH") located in Vernon (at times collectively referred to as the "Hospitals"). Ex. G, p. 24

2. ECHN's care network consists of the following wholly owned entities:
   - MMH
   - RGH
   - ECHN ElderCare Services, Inc. ("Woodlake at Tolland")
   - Visiting Nurse and Health Services of Connecticut, Inc.
   - A Caring Hand, LLC
   - Clinically Integrated Network of Eastern Connecticut, LLC
   - Connecticut Healthcare Insurance Company
   - ECHN Corporate Services, Inc.
   - Medical Practice Partners, LLC
   - ECHN Enterprises, Inc.
   - Haynes Street Property Management, LLC
   - Eastern Connecticut Medical Professionals Foundation, Inc.
   - ECHN Community HealthCare Foundation, Inc.

   Ex. G, pp. 24-25

3. Additionally, ECHN or an ECHN affiliate has ownership interests in the following joint ventures: Evergreen Endoscopy Center, LLC, WBC Connecticut East, LLC, Aetna Ambulance Service, Inc., Metro Wheelchair Service, Inc., Ambulance Service of Manchester, LLC, Connecticut Occupational Medicine Partners, LLC, Eastern Connecticut Physician Hospital Organization, Inc., Northeast Regional Radiation Oncology Network, Inc., Tolland Imaging Center, LLC, Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC, and Evergreen Medical Associates II, LLC (collectively, the "Joint Ventures"). Ex. G, p. 25

4. The chart on the following page depicts ECHN's current organizational structure. Ex. G, p. 1836


Eastern Connecticut Health Network, Inc.
ECHN Joint Ventures
ECHN Corporate Services, Inc.
Medical Practice Partners, LLC
Connecticut Healthcare Insurance Co.
ECHN Enterprises, Inc.
ECHN Enterprises Joint Ventures
Haynes Street Property Management, LLC
ECHN Community Healthcare Foundation, Inc.
Clinically Integrated Network of Eastern Connecticut, LLC
Visiting Nurse and Health Services of Connecticut, Inc.
A Caring Hand, LLC
Eastern Connecticut Medical Professionals Foundation, Inc. d/b/a Eastern Connecticut Medical Professionals
ECHN Eldercare Services, Inc. d/b/a Woodlake at Tolland Rehabilitation & Nursing Center
The Rockville General Hospital Incorporated
The Manchester Memorial Hospital
Haynes Street Medical Associates, LLC
Haynes Street Medical Associates II, LLC
Evergreen Medical Associates, LLC
Evergreen Medical Associates II, LLC
Northeast Regional Radiation Oncology Network, Inc. d/b/a Community Cancer Care
Tolland Imaging Center, LLC
Evergreen Endoscopy Center, LLC
WBC Connecticut East, LLC
Ambulance Service of Manchester, LLC
Aetna Ambulance Service, Inc.
Metro Wheelchair Service, Inc.
Connecticut Occupational Medicine Partners, LLC
Eastern Connecticut Physician Hospital Organization, Inc.
For Profit Entity

5. ECHN serves the following nineteen towns in eastern Connecticut: Andover, Bolton, Coventry, Ellington, Manchester, South Windsor, Tolland, Vernon, Willington, Ashford, Columbia, East Hartford, East Windsor, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union (the "Service Area"). Ex. G, p. 24

6. ECHN's financial condition has been strained since 2001, limiting its access to the capital required to improve infrastructure and recruit physicians. ECHN lost more than $9 million from operations over the last 15 years and its pension liability has grown from $9 million to $63 million over the same span. Ex. Z, Prefiled Testimony of Peter J. Karl, President and CEO, ECHN, p. 3341; Ex. BB, pp. 3955, 3957; Ex. G. pp. 25, 1921-23

7. ECHN has attempted to improve its financial situation through various initiatives, including hiring freezes, wage freezes, reductions in workforce, and a reduced workweek. This has included a reduction of 200 positions in recent years. Despite these measures, a large portion of ECHN's cash flow has been required to fund debt service and pension obligations, making capital investments difficult. Ex. G, p. 35; Tr., Testimony of Peter J. Karl on 3/30/16, p. 21; Ex. BB, p. 3955

8. In 2011, ECHN began exploring whether potential affiliations with another health care system would enable ECHN to better serve the community. At the time, ECHN believed it had five years until its financial circumstances would become dire. Ex. G, p. 36; Tr., Testimony of Dennis O'Neill, M.D., Chairman of ECHN Board of Trustees, on 3/30/16, p. 15

9. In November of 2012, ECHN conducted a request for proposal ("RFP") process and a Transaction Committee was established by the ECHN Board of Trustees to evaluate the proposals. As a result of this RFP process, a regulatory approval process was initiated in June of 2014 for the acquisition of ECHN's assets by a joint venture to be formed by Yale New Haven Health System and Tenet Healthcare. However, Tenet informed ECHN in December of 2014 that it was withdrawing from the process. Ex. G, pp. 38-39

10. In 2015, the Transaction Committee conducted a second RFP process. The Transaction Committee evaluated the three proposals received against selection criteria and requested further information from each respondent. The Transaction Committee then reviewed financial, quality and corporate compliance data for each respondent. Each proposal was evaluated for its ability to satisfy ECHN's financial needs and liabilities, any antitrust considerations, and state regulatory requirements for a hospital conversion. The Transaction Committee also made site visits to hospitals recently merged with or acquired by the respondents. Ex. G, pp. 39-42

11. In June of 2015, the Transaction Committee decided to negotiate solely with PMH. After reviewing the Letter of Intent and the draft Asset Purchase Agreement ("APA") negotiated with PMH, the Transaction Committee recommended that the ECHN Board of Trustees accept the proposal. On June 25, 2015, a unanimous vote of the ECHN Board of Trustees approved the Letter of Intent and APA, and on July 29, 2015 ECHN's Corporators approved the APA. Ex. G, pp. 42-43, 107-120, 122-214, 396

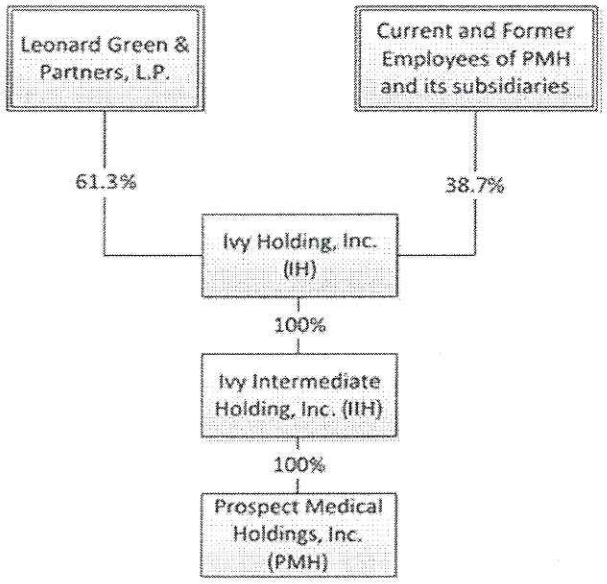
12. The Applicants are requesting approval of the proposed asset purchase (the "Asset Purchase") as a solution to ECHN's long-standing challenges that offers the Service Area continued access to its services and facilities. Ex. G, p. 26

13. PMH is a for-profit, privately owned national healthcare services company with its principal place of business in Los Angeles, California. PMH owns fourteen acute care and behavioral hospitals in California, New Jersey, Rhode Island and Texas. It also owns a network of specialty and primary care clinics in each of these regions. Ex. G, pp. 25, 27; Ex. Z, Prefiled Testimony of Von Crockett, Senior Vice President of Corporate Development, PMH, p. 3355

14. Through PMH's medical group segment, PMH also manages the provision of physician services in each of its markets through a network of approximately 8,900 physicians. The physician networks operate as independent practice associations ("IPAs") that contract with PMH-owned management service organizations ("MSOs"). The IPAs are comprised of both PMH-employed and independent community physicians and other allied health professionals. Ex. G, p. 25; Ex. K, p. 2159; Ex. N, p. 3231

15. PMH aligns its hospitals and physician networks under a model called Coordinated Regional Care ("CRC"). CRC provides for clinical integration of hospitals, physicians and community providers with health plans and other payers through value driven and risk-based reimbursement systems. PMH believes that the CRC model improves quality, efficiency and financial performance while providing its patients with quality, affordable healthcare. Ex. G, p. 26

16. The chart below shows PMH's ownership structure.



Ex. K, p. 2205

17. ECHN selected PMH as the proposed purchaser because its financial resources and access to capital are anticipated to maintain ECHN's assets as economically viable and vibrant parts of the healthcare system in Eastern Connecticut by permitting capital investments, better preparing MMH and RGH to participate in new value-based delivery models, offering enhanced practice options for physicians, strengthening its network of providers and allowing for other improvements in operations. Ex. Z, Prefiled Testimony of Dennis O'Neill, p. 3333

18. In its audited financial statements for FY 2015, PMH reported total revenues of over $1.3 billion from its operations on a consolidated basis. As of fiscal year end 2015, PMH reported free cash flow of over $112 million and close to $75 million in cash from operations. The company also received credit upgrades by both Moody's and S&P in 2015, with Moody's rating PMH's bonds as B1 and S&P rating PMH's bonds as B. These ratings still stand as of May 3, 2016. Ex N, pp. 3245, 3249-59; Tr., Testimony of Steven Aleman, Chief Financial Officer, PMH, on 5/3/2016, p. 113

19. Under the APA, PMH will pay $105 million for substantially all the assets of ECHN, including both Hospitals (a) plus any excess of net working capital over $24 million or minus any net working capital under $24 million; (b) minus the value of certain ECHN liabilities assumed by PMH (including ECHN's unfunded pension obligations, captive insurer liability, capital leases and workers' compensation liability); (c) minus asbestos abatement liability of up to $1 million; and (d) in the event that ECHN is unable to assign and transfer its interest in any ECHN Joint Venture to PMH, minus a dollar amount to be fixed in advance for each ECHN Joint Venture. Ex. G, pp. 29, 145

20. Certain assets of ECHN will be excluded from the sale, including certain cash and cash equivalents of ECHN, all short-term and long-term investments other than ECHN's investments in the Joint Ventures, board-designated, restricted and trustee-held or escrowed funds, beneficial interests in charitable assets and accrued earnings on all of the foregoing. These assets will be transferred to a new, independent charitable entity (the New Foundation") established by ECHN. The New Foundation will use the charitable assets for appropriate charitable health care purposes in the communities traditionally served by ECHN. Ex. G, pp. 29, 49, 312-13; Ex. BB, p. 3338.

21. There is no financing contingency with respect to the transaction. PMH anticipates funding the transaction using its existing cash and also has access to a $40 million revolving line of credit with Morgan Stanley that has been pre-approved. In order to draw on this line, PMH provides a 24 hour advance verbal notice to the lenders. Ex. G., p. 78; Ex. K, p. 2191

22. The transaction is estimated to require $28 million in cash from PMH at closing. PMH currently has in excess of $65 million in cash and is anticipated to have close to $100 million in cash on hand by the time the Asset Purchase closes, as a result of its growth in revenues that is generating between $10-15 million of free cash flow on a monthly basis. PMH currently has less cash than previously reported due to the recent acquisition of East Orange General Hospital in New Jersey. The revolving line of credit, which PMH recently drew down to $10

million to finance its purchase of East Orange General Hospital, is also expected to be restored to $30 million by the time of closing. Ex. K, p. 2192; Ex. UU.; Tr., Testimony of Steven Aleman, CFO, PMH, on 3/29/2016, p. 152-53

23. The proceeds from the Asset Purchase will be used first to settle all of ECHN's indebtedness not otherwise assumed by PMH, then to fund the indemnity reserve for payment of ECHN liabilities to PMH that may arise post-closing. Any funds remaining in the reserve after a specified period will be transferred as directed by the OAG. Ex. G, p. 30

24. Table 1 summarizes the net proceeds and flow of funds associated with the Asset Purchase as of March 31, 2016 compared to September 30, 2015, including ECHN's anticipated plan for payment of debt and pension obligations as well as payment of other liabilities. The amounts are subject to adjustment at the closing date ("Closing Date").

TABLE 1
APA PROJECTED NET PROCEEDS AND FLOW OF FUNDS

			Actual 9/30/2015	Actual 3/31/2016
ACQUISITION PRICE (EV)	A		105,000,000	105,000,000
ASSUMED ASSETS & LIABILITIES: Pension & Retiree Medical			(62,598,000)	(67,598,000)
Captive & Workers Comp.			(1,705,000)	(1,705,000)
Net Working Capital True-up			(9,107,000)	(8,275,000)
RGH Eating Disorder Loan			0	0
Seller's Reimbursable Costs			(424,000)	(424,000)
Capital Leases			(6,764,000)	(5,922,000)
Asbestos Abatement			(1,000,000)	(1,000,000)
TOTAL ACQ LIABILITIES	B		(81,598,000)	(84,924,000)
THRESHOLD on LIABILITIES	C		(77,000,000)	(77,000,000)
GUARANTEED NET PROCEEDS	D	A-C	28,000,000	28,000,000
CASH & INVESTMENTS (ECHN) *	E		58,454,000	54,968,000
TOTAL CASH for DEBT PAYOFF	F	D+E	86,454,000	82,968,000
LONG TERM DEBT	G		(78,420,000)	(75,896,000)
SURPLUS after DEBT DEFEASANCE	H	F-G	8,034,000	7,072,000
Post-Closing Pool "Wind Down" Funds			1,000,000	1,000,000
Excess Liabilities Assumed		B-C	(4,598,000)	(7,924,000)

Funds Remaining after PMH Reimbursed	K	H-I+J	2,436,000	(1852,000)
Deduction to Capital Commitment**	L		0	1852,000
Available for Indemnity Reserve	M	K+L	2,436,000	0
Legacy ECHN ***			2,229,000	2,139,000

* PMH is assuming a $5 million loan for the RGH Eating Disorder Unit without a price deduction. To the extent that cash is available beyond the $1 million for post-closing costs and $4 million for the indemnity reserve, ECHN can mitigate a deduction to the capital commitment up to $5 million.
** If line K is less than zero, then there was not sufficient ECHN cash left to make PMH whole on additional liabilities assumed, thus a dollar for dollar reduction to the $75 million capital commitment applies.
*** Estimated value of future settlements on funds due from Medicare and Medicaid less funds due to Medicare and Medicaid for prior years that are still pending final review. The amounts are net of various balance sheet accounts that will not be part of the acquisition.
Late File 8, dated Apr. 20, 2016; Ex. TT

25. After the closing of the proposed Asset Purchase, the assets of ECHN will be transferred to Prospect ECHN, Inc. ("New ECHN") or one or more of its affiliates. New ECHN will serve as the health system parent company and sole shareholder of the PMH affiliates that will hold the hospital licenses for MMH and RGH after the closing of the proposed Asset Purchase (the post-closing for-profit hospitals will be referred to individually as "New MMH" and "New RGH" and collectively as "New Hospitals.") Ex. G, p.1838; Late File 13, dated Apr. 20, 2016

26. For at least three years after the Closing Date, PMH will continue operating New MMH and New RGH in their current locations as acute care hospitals with emergency departments, will maintain an ownership interest in ECHN's current post-acute care continuum of care network and will require any wholly owned entity involved with such post-acute care continuum of care network to maintain appropriate service lines. Ex. G, pp. 32, 110

27. PMH has no plans to eliminate any currently offered services at MMH or RGH after the Closing Date. No service line or service location changes are currently planned in connection with the proposed Asset Purchase, although it is expected that the ECHN ambulatory network will be expanded and services configured to promote the most efficient delivery of coordinated care following the closing. Ex. K, p. 2189

28. Following the closing, New MMH and New RGH will each maintain an advisory board subordinate to PMH's Board of Directors and made up of community representatives, physicians on the medical staffs of New MMH and New RGH, and the New Hospitals' CEO (the "Local Board"). PMH plans to appoint the same individuals to the Local Board of New MMH and the Local Board of New RGH and to have the boards meet concurrently to encourage interaction within the system. PMH will schedule regular standing meetings to update the Local Board. Ex. G, p. 30; Ex. K, p. 2165

29. The initial members of the Local Board will include at least five members of ECHN's Board of Trustees. The Local Board will serve as a resource for PMH with respect to investment of the $75 million commitment amount (the "Commitment Amount") set forth in the APA, assist with maintenance and implementation of a strategic business plan for the New Hospitals, and assist with medical staff credentialing, quality assurance programs and accreditation at the New Hospitals. Ex. G, p. 30

30. During such periods that PMH operates the New Hospitals, it has agreed to maintain ECHN's commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under government payment programs. Ex. G, p. 181

31. PMH has had to significantly modify its own Quality Assurance and Performance Improvement ("QAPI") as a result of recent surveys of two of PMH's California hospitals, Los Angeles Community Hospital and Southern California Hospital, resulting in the California Department of Health imposing Immediate Jeopardy citations. Ex. Z, Prefiled Testimony of Von Crockett, pp. 3355-57; Ex. K, pp. 2684-2808, 2835-3020; Ex. Z, pp. 3402-77, 3479-3645

32. ECHN's representatives learned of the Immediate Jeopardy situations on February 1, 2016. In response, the ECHN Board of Trustees appointed a Quality Evaluation Team to investigate whether there were systemic problems suggesting PMH might be an unreliable buyer from a quality and patient safety perspective. The team members visited PMH's CharterCare hospitals in Rhode Island to review their quality program and met with quality personnel at various PMH hospitals, including California and Rhode Island. ECHN concluded that the compliance issues were isolated and that PMH demonstrated a strong commitment to remediate the problems. Based on this information, on March 23, 2016, the ECHN Board of Trustees confirmed its commitment to proceed with the transaction. Tr., Testimony of Peter Karl on 3/29/16, p. 101; Late File 1, dated Apr. 20, 2016; Ex. Z, Prefiled Testimony of Joy Dorin, Vice Chair, ECHN Board of Trustees, p. 3352

33. On March 28, 2016, the parties entered into a Quality Commitment Letter pursuant to which PMH agreed to maintain certain ECHN quality programs for the first two years after the Closing Date and not modify them without approval of the Local Board. The Quality Commitment Letter also requires that PMH maintain QAPI programs consistent with best practices and those currently implemented in PMH's Rhode Island facilities while also acknowledging that the Local Board shall oversee quality programs at the New Hospitals. Tr, Testimony of Jonathon Spees, Senior Vice President of Mergers and Acquisitions, PMH, on 3/30/16, p. 80; Ex. EE

34. With respect to quality activities, ECHN currently functions as a high reliability organization ("HRO") committed to empowering all levels of employees to notify administrators of any patient care issues and fixing processes, leading to consistent delivery care and improved outcomes. PMH is supportive of ECHN's HRO status. Tr., Testimony of Von Crockett on 3/29/2016, p. 49; Tr., Testimony of Mitchell Lew, President, PMH, on 3/29/2016, p. 68-69

35. Additionally, as a result of the Immediate Jeopardy citations, PMH has hired a corporate level Chief Quality Officer, Chief Clinical Officer, Chief Nursing Officer and an Associate Vice President of Regulatory and Patient Safety to assist in providing necessary resources to implement all quality programs at its local hospitals and share best practices among the hospitals. Ex. Z, Prefiled Testimony of Von Crockett, pp. 3355-57

36. PMH is also establishing an Eastern region quality team and will hire a regional Director of Quality by the time of closing of the Asset Purchase. This regional team will serve as a resource for the New Hospitals, as well as PMH hospitals located in New Jersey, Rhode Island and Pennsylvania. When one of the New Hospitals has a question about a corporate practice or policy, the Eastern region quality team will have the ability to be on-site in order to assist the local team. Tr., Testimony of Peter Karl on 3/30/2016, pp. 144-47

37. Other PMH initiatives include retaining a national consulting firm and legal counsel to assist in preparedness and responses to Centers for Medicare & Medicaid Services surveys. Under PMH's draft QAPI program, a Hospital Quality & Patient Safety Committee will be developed at each of the New Hospitals, with oversight over subcommittees and workgroups that address the hospital's unique needs. These committees will report to a Regional Quality and Patient Safety Steering Council, which will report to the Corporate Quality and Patient Safety Steering Council. Tr., Testimony of Von Crockett on 3/29/15, pp. 93-94; Ex. Z, Prefiled Testimony of Von Crockett, pp. 3356-57; Ex. Z, pp. 3402-03; Late File 1, dated Apr. 20, 2016; Late File 10, dated Apr. 20, 2016

38. The APA commits PMH to expend the Commitment Amount in capital projects to upgrade the New Hospitals' facilities and services over the next five years. However, the APA also provides that the Commitment Amount is subject to a dollar-for-dollar reduction if ECHN has more than $77 million of liabilities on the Closing Date other than long-term debt and there is not enough available cash or money in the indemnity reserve established under Section 9.8 of the APA to cover the excess liabilities being assumed by PMH. Ex. G, pp. 146-47, 181, 199

39. PMH intends to fund its capital commitments through the operations of ECHN, PMH's existing cash at the time of expenditure or, if necessary, PMH's corporate level credit facility. Ex. G, p. 78

40. The APA provides that the Commitment Amount will be spent on (a) capital projects, including routine and non-routine capital expenditures for the improvement of facilities and/or the acquisition, development, expansion and improvement of hospital, ambulatory or other health care services; (b) de novo development, expansion or acquisition of a department, program, service or facility; (c) upgrades or renovations generally; (d) deferred maintenance items; and (e) recruitment of medical staff. Ex. G, pp. 181-82

41. The Commitment Amount has not been specifically apportioned to each hospital or its affiliates. Allocations of the Commitment Amount will be made by PMH after it receives input from the Local Board and medical staff. Ex. E, p. 78

42. After closing, PMH and the Local Board will develop a strategic capital plan. The capital projects in Table 2 below have been identified by ECHN management as priority capital projects. The projects will require PMH approval with input of the Local Board. Ex. G, pp. 31, 82

TABLE 2
CAPITAL PRIORITY PROJECTS IDENTIFIED BY ECHN (IN MILLIONS)

Description	Estimated Cost (In Millions)
1. Upgrades to emergency department for behavioral health patients (MMH)	$1.1
2. Electronic medical record system replacement (MMH & RGH)	$20
3. Upgrades to nursing units (RGH)	$6.6
4. Upgrades to nursing units (MMH)	$11
5. Vessel sealing systems (MMH & RGH)	$0.6
6. MRI replacement (MMH)	$1.6
7. SPECT scanner replacement (MMH)	$0.4
Total Estimated Cost	**$41.3**

Ex. E, p. 82; Ex. H, p. 2193

43. PMH has also provided a list of immediate estimated capital expenditures at the New Hospitals, as well as the Woodlake at Tolland nursing and rehabilitation facility, that it plans to address within 3 years of closing at a total estimated cost of approximately $11.8 million. Table 3 below shows the timeline for these expenditures, which are mainly comprised of deferred maintenance to the physical plants of these facilities.

TABLE 3
PRIORITY FACILITY CAPITAL NEEDS OF ECHN

Facility	Year 1	Year 2	Year 3	Total
Manchester Memorial Hospital	$3,455,000	$2,225,000	$2,020,000	$7,700,000
Rockville General Hospital	$727,000	$916,000	$1,370,000	$3,013,000
Woodlake at Tolland	$439,700	$137,000	$487,500	$1,064,200
Total estimated expenditures				**$11,770,200**

Late File 12, dated Apr. 20, 2016

44. In recent years, ECHN reported that it has spent very little on capital improvements other than required expenditures to repair or replace plant and equipment. Additionally, creditors have become reluctant to work with ECHN on large projects that would require financing until it is acquired. Ex. G, p. 83; Tr., Testimony of Michael Veillette, CFO, ECHN, on 3/29/2016, p. 161

45. After the Asset Purchase, capital will be available to ECHN for replacements and upgrades to systems and the infrastructures of ECHN's facilities; investments to improve the sharing of electronic medical records in order to improve the collection and documentation of information and to enhance the availability of information for critical treatment decisions for patients; upgrades to medical equipment and technology to provide patients access to state-of-the-art technology for diagnosis, care and treatment; and program development to attract and retain physicians. Ex. G, p. 57

46. As of the closing, PMH or its affiliates will offer employment to substantially all ECHN employees who are in good standing, in positions and at salaries at least equal to those then being provided by ECHN and with benefits packages comparable to those offered to similarly-situated employees at other hospitals operated by PMH. Ex. G, pp. 31, 171

47. PMH will maintain and support financially ECHN's University of New England medical student and other health profession teaching programs, as well as ECHN's graduate medical education programs, while operating at a level not to exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by the Centers for Medicare and Medicaid Services. Ex. G, pp. 32, 181

48. In addition to continued support of its teaching programs, ECHN believes that PMH's CRC model will help overcome challenges in retaining and recruiting physicians that it has faced in recent years. PMH has developed significant experience in other markets regarding ways hospitals can attract more primary care providers and improve access to care. Recently, PMH succeeded in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners participating in PMH's Rhode Island physician network at the end of 2015, only 18 were employed by the CharterCare System when PMH acquired its two hospitals in mid-2014. Ex. G, p. 75; Ex. K, p. 2177-78

49. In order to implement the CRC strategy, PMH has established an IPA entity in Connecticut (Prospect Provider Group CT-ECHN, LLC, or "PPGCTE") and a preferred provider network/health system risk taking entity, Prospect Health Services, CT, Inc., that will contract with payers on behalf of PPGCTE physicians. These two organizations, through management services agreements with PMH, will manage physician participation, risk contracting and care management activities for participating members. Ex. K, p. 2158

50. The goal of the CRC model is to reduce the overall cost of health care by increasing preventive care and early readmissions, reducing inpatient utilization and reducing emergency room visits. PMH will achieve these goals by developing a healthcare delivery network encompassing the entire continuum of patient care, including inpatient services, home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health related services. Ex. K, p. 2192; Ex. G, pp. 76, 107

51. PMH has demonstrated the efficacy of the CRC model in Southern California, Texas and Rhode Island. In these regions, PMH has improved clinical outcomes, increased quality scores,

increased patient satisfaction, reduced readmission rates, reduced average lengths of stay, and reduced medical-cost ratios. For example, from 2012 to 2014 in California and Texas, where PMH participates in HMO contracts for seniors, PMH reduced hospital bed days per thousand from 1,260 to 720. Additionally, length of hospital stay for this population has been reduced from 5.1 to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. The CRC model has also enabled PMH to attract more primary care providers and has improved access to care. Ex. G, pp. 73, 75-76

52. Subject to changes in legal requirements or governmental guidelines or policies, PMH will ensure that New MMH and New RGH maintain and adhere to ECHN's current policies regarding charity care, bad debt, indigent care, community volunteer services and community benefits or adopt other policies that are at least as favorable to the indigent and uninsured in the aggregate as ECHN's current policies. ECHN's policies are generally comparable to such policies at PMH's other hospitals. Ex. G, pp. 32, 75, 93, 181, 1912-19; Ex. K, p. 3233; Ex. Z, Prefiled Testimony of Jonathon Spees, p. 3379

53. PMH will continue to provide financial support for community benefit and community building activities in the Manchester/Rockville Area to the same degree as ECHN did in FY 2014. The spending by PMH for community building activities post-closing is projected to increase 1% each year through FY 2019, and the spending for both community benefit and community building activities post-closing assumes no change in the Medicaid population served or the complement of community benefit programs offered by New MMH and New RGH. Ex. G, pp. 96, 99.

54. Table 4 below describes the socioeconomic condition of the ECHN Service Area towns in comparison to the state of Connecticut as a whole and shows the areas most in need of such programs.

TABLE 4
SOCIOECONOMIC STATUS OF THE SERVICE AREA

Socioeconomic Data

	Town	Poverty Rate[1]	Median Household Income[1]	Unemployment Rate[2]	Median Age[1]
PSA	Andover	4.9%	$97,762	6.4%	43
	Bolton	2.1%	$87,885	6.0%	47
	Coventry	3.5%	$92,308	7.1%	43
	Ellington	2.7%	$84,934	6.0%	40
	Manchester	8.9%	$63,656	7.4%	37
	South Windsor	4.3%	$91,519	5.9%	42
	Tolland	3.7%	$103,358	5.5%	41
	Vernon	9.2%	$61,848	7.5%	41
	Willington	18.1%	$70,013	5.5%	35

SSA	Ashford	4.2%	$75,242	7.2%	38
	Columbia	3.8%	$92,973	6.4%	47
	East Hartford	15.3%	$48,438	9.8%	39
	East Windsor	5.0%	$71,310	7.4%	42
	Glastonbury	2.6%	$106,872	5.3%	43
	Hebron	0.9%	$114,286	5.4%	42
	Mansfield	17.9%	$67,615	7.2%	21
	Somers	4.8%	$100,100	7.2%	42
	Stafford	6.7%	$63,672	8.1%	40
	Union	1.1%	$83,500	5.5%	42
	State	10.0%	$69,519	7.8%	40

(1)2012

(2)2013

Source: Connecticut Economics Resource Center Town Profile October, 2014.

Ex. G, p. 63

55. The Rockville section of Vernon, where RGH is located, has been designated as a Medically Underserved Population by the Health Resources and Services Administration, and the northwestern part of Mansfield has been designated as a Health Professional Shortage Area for Primary Medical Care. RGH, MMH and ECHN affiliates currently provide safety net services to this region. This proposal will support the availability of health care services to the vulnerable populations in the Service Area. Ex. G, p. 63

56. In 2013, MMH and RGH collaborated to conduct a Community Health Needs Assessment ("CHNA"), which identified the current and future health care needs of the community. The four priority health needs identified were heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence. An implementation plan was developed to respond to the identified health needs. Ex. G, pp. 70, 1781-87, 1789-95

57. PMH and its affiliates will support the priority needs identified by the CHNA with physician alignment and population health management strategies, enhanced through implementation of CRC, which focuses on the health of vulnerable populations. PMH has committed to implement and support the current CHNA through 2016 and conduct another CHNA for the Service Area over the next two years and to implement the recommendations of such study as deemed necessary and appropriate. Ex. G, pp. 70-71; Ex. Z, Prefiled Testimony, Von Crockett, p. 3362

58. PMH has stated that New MMH and New RGH will be in compliance with the following general community benefit standards for at least the first three years: (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusions of other qualified

doctors; (c) the New Hospitals shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24/7 emergency departments and provide emergency services to patients regardless of their ability to pay. *Tr. Testimony of Tom Reardon, President, PMH East, on 5/3/16, pp. 103-04*

59. PMH and ECHN representatives have already met with leadership for Connecticut's Medicaid Program at the Department of Social Services ("DSS") and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. PMH is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state. In addition, PMH will actively work with other providers in the community such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the Service Area, including Medicaid recipients. Ex. G, pp. 74-75

60. The patient populations currently served by the Hospitals is not expected to change as a result of the Asset Purchase. PMH will accept all existing contracts with payers and will complete a change of ownership process with commercial payers, as well as Medicare and the Connecticut Medical Assistance Program (Medicaid). Table 5 below describes the current patient population/payer mix for MMH and RGH, as well as the projected mix for the New Hospitals. Ex. G, p. 85

TABLE 5
PATIENT POPULATION/PAYER MIX

Manchester Memorial	Current FY 2015	Projected FY 2016	Year 1 FY 2017	Year 2 FY 2018	Year 3 FY 2019
Medicare (1)	41.39%	41.39%	41.39%	41.39%	41.39%
Medicaid (2)	17.24%	17.24%	17.24%	17.24%	17.24%
CHAMPUS or TriCare	0.43%	0.43%	0.43%	0.43%	0.43%
Total Government Payers	**59.06%**	**59.06%**	**59.06%**	**59.06%**	**59.06%**
Commercial Insurers (1)	38.05%	38.05%	38.05%	38.05%	38.05%
Uninsured	2.37%	2.37%	2.37%	2.37%	2.37%
Workers Compensation	0.52%	0.52%	0.52%	0.52%	0.52%
Total Non-Government Payers	**40.94%**	**40.94%**	**40.94%**	**40.94%**	**40.94%**
Total Payer Mix	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Rockville General	**Current FY 2015**	**Projected FY 2016**	**Year 1 FY 2017**	**Year 2 FY 2018**	**Year 3 FY 2019**
Medicare (1)	31.00%	31.00%	31.00%	31.00%	31.00%
Medicaid (2)	17.66%	17.66%	17.66%	17.66%	17.66%
CHAMPUS or TriCare	0.56%	0.56%	0.56%	0.56%	0.56%
Total Government Payers	**49.22%**	**49.22%**	**49.22%**	**49.22%**	**49.22%**
Commercial Insurers (1)	46.38%	46.38%	46.38%	46.38%	46.38%
Uninsured	3.50%	3.50%	3.50%	3.50%	3.50%
Workers Compensation	0.90%	0.90%	0.90%	0.90%	0.90%
Total Non-Government Payers	**50.78%**	**50.78%**	**50.78%**	**50.78%**	**50.78%**
Total Payer Mix	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

(1) Includes managed care activity
(2) Includes managed care activity and other medical assistance
Ex. G, p. 84-85

61. PMH's acquisitions of other health systems and hospitals have resulted in improved financial performance at many of the systems. Table 6 below illustrates the financial performance of some of PMH's hospitals after they were acquired by PMH.

TABLE 6
PMH'S RECENT ACQUISITIONS FINANCIAL PERFORMANCE (in Thousands)

Entity	EBITDA			Working Capital			Stockholder's Equity		
	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015
Nix Health System (a)	$14,905	$18,411	$8,043	$5,937	$36,785	$35,449	$13,122	$20,468	$63,789
Roger Williams Medical Center (b)	$3,942	$1,582	$9,080	($1,860)	$1,114	$6,230	$37,184	$34,099	$38,256

Our Lady of Fatima Hospital(c)	($893)	$509	$6,485	$1,904	$2,040	$3,432	($57,150)	$27,513	$28,107

(a) Nix is a Health System based in Texas. Nix's Earnings Before Interest, Taxes, Depreciation and amortization (EBITDA) is based on reported trailing twelve months ended on 1/31/2011. Declines in EBITDA between 2014 and 2015 were due to the fluctuation in net reimbursement related to payments made to the Service Organization of San Antonio "SOSA". Funding to SOSA is voluntary but it is projected to average approximately $12M a year based on budgeted spending initiatives of the service organization. In 2014 the funding requirements were $5.7M (lower by approximately $6.3M) and in 2015 funding requirements returned to $12M. The remaining difference was comprised of lower volume at the facility as services were reconfigured and medical staff turnover. Working Capital of Nix prior to acquisition is as of 1/31/2011 and includes cash which was not part of assets acquired by Prospect.

(b) EBITDA for Roger Williams Medical Center, located at Providence , Rhode Island, for Year Prior to Acquisition is only for-8 months ending on May 31, 2014 and EBITDA for FY2014 is only for three months post acquisition for FYE 9/30/2014. Working Capital is for prior to acquisition is as of 5/31/2014 and includes cash which was not part of assets acquired by Prospect and as prior to the acquisition it was a non-profit organization, therefore, Net Assets were used as a substitute for Stockholder's Equity.

(c) EBITDA for Our Lady of Fatima Hospital in Rhode Island for Year Prior to Acquisition is only for 8 months ending on May 31, 2014 and for FY2014 is only for three months post acquisition for FYE 9/30/2014. Working Capital prior to acquisition is as of 5/31/2014 and includes cash which was not part of assets acquired by Prospect and prior to the acquisition was a non-profit organization, therefore, Net Assets were used as a substitute for Stockholder's Equity.

Late File 19, dated Apr. 20, 2016; Ex. QQ, dated May 9, 2016

62. Financial benefits associated with this proposal include: operational efficiencies and economies of scale, participation in PMH's purchasing power, supply chain benefits, employee benefits savings and streamlined revenue collection. PMH also makes available to its hospitals subject matter consultants who are employed by PMH, saving its hospitals the cost of hiring consultants in those areas. Ex. G, p. 57; Ex. Z, Prefiled Testimony of Jonathon Spees, p. 3379; Ex. Z, Prefiled Testimony of Von Crockett, pp. 3358-59; Ex. N, p. 3236

63. Tables 7 and 8 below represent MMH's projected revenues and expenses from operations with and without this proposal, projecting gains from operations for MMH with the CON at $11.6 million (before income taxes) by FY 2019, as opposed to $6.7 million without the CON.

TABLE 7
MMH PROJECTED REVENUES AND EXPENSES WITH CON

	FY 2017	FY 2018	FY 2019
Total Operating Revenue	$191,485,686	$196,943,847	$202,818,436
Total Operating Expenses	$181,570,103	$186,486,220	$191,183,170
Gain/Loss from Operations	**$9,915,583**	**$10,457,627**	**$11,635,266**
Provision for Income Taxes	**$4,254,950**	**$4,482,606**	**$5,030,134**
Gain/Loss from Operations	**$5,660,633**	**$5,975,021**	**$6,605,133**

Ex. K, p. 2314

TABLE 8
MMH PROJECTED REVENUES AND EXPENSES WITHOUT CON

	FY 2017	FY 2018	FY 2019
Total Operating Revenue	$189,022,494	$192,255,217	$195,904,378
Total Operating Expenses	$183,683,229	$186,432,862	$189,232,208
Gain/Loss from Operations*	**$5,339,265**	**$5,823,000**	**$6,672,170**

*Provision for income taxes doesn't apply to not-for-profit entities.
Ex. K, p. 2314

64. Tables 9 and 10 represents RGH's projected revenues and expenses from operations with and without this proposal, projecting gains from operations for RGH with the CON at $1.6 million (before income taxes) by FY 2019, as opposed to $114,525 without the CON.

TABLE 9
RGH PROJECTED REVENUES AND EXPENSES WITH CON

	FY 2017	FY 2018	FY 2019
Total Operating Revenue	$70,634,865	$72,732,353	$74,987,275
Total Operating Expenses	$69,632,163	$71,490,737	$73,368,375
Gain/Loss from Operations	**$1,002,702**	**$1,241,616**	**$1,618,900**
Provision for Income Taxes	**$419,357**	**$607,900**	**$766,359**
Gain/Loss from Operations	**$583,345**	**$633,715**	**$852,541**

Ex. K, p. 2316

TABLE 10
RGH PROJECTED REVENUES AND EXPENSES WITHOUT CON

	FY 2017	FY 2018	FY 2019
Total Operating Revenue	$69,583,227	$70,771,104	$72,116,415
Total Operating Expenses	$69,891,198	$70,937,011	$72,001,890
Gain/Loss from Operations*	**($307,971)**	**($165,907)**	**$114,525**

*Provision for income taxes doesn't apply to not-for-profit entities.
Ex. K, p. 2316

65. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. Conn. Gen. Stat. § 19a-639(a)(1)

66. The application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. Conn. Gen. Stat. § 19a-639(a)(2)

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

68. The Applicants have demonstrated that the proposal will improve the overall financial strength of the health care system and that it is financially feasible. Conn. Gen. Stat. §19a-639(a)(4)

69. Subject to the conditions below, the Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. Conn. Gen. Stat. §19a-639(a)(5)

70. Subject to the conditions below, the Applicants have shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. Conn. Gen. Stat. §19a-639(a)(6)

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

72. The historical utilization of ECHN's services in the service area support this proposal. Conn. Gen. Stat. §19a-639(a)(8)

73. 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)

74. Subject to the conditions below, the Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. Conn. Gen. Stat. §19a-639(a)(10)

75. The Applicants have satisfactorily demonstrated that the proposal will not have a negative impact on the diversity of health care providers in the area. Conn. Gen. Stat. §19a-639(a)(11)

76. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. Conn. Gen. Stat. §19a-639(a)(12)

Discussion

CON applications are decided on a case-by-case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considered the factors set forth in Connecticut General Statutes § 19a-639(a) and 19a-486d. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board,* 309 Conn. 727 (2013).

ECHN is a not-for-profit health care system that is the parent company of two acute care hospitals in Connecticut, MMH located in Manchester and RGH located in Vernon. *FF1* ECHN's Service Area is comprised of the following nineteen towns in eastern Connecticut: Andover, Bolton, Coventry, Ellington, Manchester, South Windsor, Tolland, Vernon, Willington, Ashford, Columbia, East Hartford, East Windsor, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union. *FF5* PMH is a for-profit, privately owned national healthcare services company with its principal place of business in Los Angeles, California. PMH owns fourteen acute care and behavioral hospitals in California, New Jersey, Rhode Island and Texas. It also owns a network of specialty and primary care clinics in each of its regions. *FF13* ECHN's financial condition has been strained since 2001 and its mission impeded by various factors, including limited access to capital required to improve infrastructure and recruit physicians, and mounting pension liabilities. *FF6* ECHN has attempted to improve its financial situation through various initiatives, including hiring freezes, wage freezes, reductions in workforce, and a reduced workweek. Despite these measures, a large portion of ECHN's cash flow has been required to fund debt service and pension obligations, making capital investments difficult. *FF7* As a result, the Applicants are requesting approval of the proposed Asset Purchase as a solution to ECHN's long-standing challenges while ensuring the Service Area continued access to ECHN's services and facilities. *FF12*

Under the APA, PMH has committed to spend a Commitment Amount of $75,000,000 towards capital projects over the next five years. However, the APA also provides that the Commitment Amount is subject to a dollar-for-dollar reduction if ECHN has more than $77 million of liabilities on the Closing Date other than long-term debt and there is not enough available cash or money in the indemnity reserve to cover the excess liabilities (for amounts over $77 million) being assumed by PMH. *FF38* The APA provides that the $75 million Commitment Amount will be spent on (a) capital projects, including routine and non-routine capital expenditures for the improvement of facilities and/or the acquisition, development, expansion and improvement of hospital, ambulatory or other health care services; (b) de novo development, expansion or acquisition of a department, program, service or facility; (c) upgrades or renovations generally; (d) deferred maintenance items; and (e) recruitment of medical staff. *FF40*

For at least three years after the Closing Date, PMH will continue operating MMH and RGH in their current locations as acute care hospitals with emergency departments, will maintain an ownership interest in ECHN's current post-acute care continuum of care network and will require any wholly owned entity involved with such post-acute care continuum of care network to maintain appropriate service lines. *FF26* PMH has no plans to eliminate any services at MMH or RGH. No service line or service location changes are currently planned in connection with the proposed transaction, although it is expected that the ECHN ambulatory network will be expanded and services configured to promote the most efficient delivery of coordinated care following the closing. *FF27*

Following closing, MMH and RGH will each maintain a Local Board, an advisory board made up of community representatives, physicians on the respective hospital's medical staff, and the CEO of the respective hospital that will be subordinate to PMH. The initial members of the Local Board will include at least five members of ECHN's Board of Trustees. The Local Board will serve as a resource for PMH with respect to investment of the Commitment Amount, assist with maintenance and implementation of a strategic business plan for the Hospitals, and assist with medical staff credentialing, quality assurance programs and accreditation at the New Hospitals. *FF29*

After closing, PMH and the Local Board will develop a strategic capital plan. The following capital projects have been identified by ECHN management as priority capital projects:

Description	**Estimated Cost (In Millions)**
1. Upgrades to emergency department for behavioral health patients (MMH)	$1.1
2. Electronic medical record system replacement (MMH & RGH)	$20
3. Upgrades to nursing units (RGH)	$6.6
4. Upgrades to nursing units (MMH)	$11
5. Vessel sealing systems (MMH & RGH)	$0.6
6. MRI replacement (MMH)	$1.6
7. SPECT scanner replacement (MMH)	$0.4
Total Estimated Cost	**$41.3**

The projects will require PMH approval with input of the Local Board. *FF42* After the asset purchase, capital will be available to ECHN for replacements and upgrades to systems and the infrastructures of ECHN's facilities; investments to improve the sharing of electronic medical records in order to improve the collection and documentation of information and to enhance the availability of information for critical treatment decisions for patients; upgrades to medical equipment and technology to provide patients access to state-of-the-art technology for diagnosis, care and treatment; and program development to attract and retain physicians. *FF45*

PMH intends to fund its capital commitments through the operations of ECHN, PMH's existing cash at the time of expenditure or, if necessary, PMH's corporate level credit facility. *FF39* The Commitment Amount has not been specifically apportioned to each hospital or its affiliates. Allocations of the commitment will be made by PMH after it receives input from the Local Board and medical staff. *FF41*

With respect to the quality of services offered by PMH, during the course of negotiations between ECHN and PMH, it became known that PMH had to significantly modify its QAPI as a result of surveys of PMH's Southern California Hospitals as well as the survey of Los Angeles Community Hospital that resulted in the California Department of Health imposing Immediate Jeopardy citations. *FF31* As a result of these citations, PMH has hired a corporate level Chief Quality Officer, Chief Clinical Officer, Chief Nursing Officer and an Associate Vice President of Regulatory and Patient Safety to assist in providing necessary resources to implement all quality programs at its local hospitals and share best practices among hospitals. *FF35* ECHN concluded that the compliance issues were isolated and that PMH demonstrated a strong commitment to remediate the problems. Based on this information, the ECHN Board confirmed its commitment to proceed with the transaction and the parties entered into a Quality Commitment Letter pursuant to which PMH agreed to maintain certain quality programs of ECHN for the first two years after the Closing Date and not modify them without approval of the Local Board. The Quality Commitment Letter also requires that PMH maintain QAPI programs consistent with best practices and those currently implemented in PMH's Rhode Island facilities while also acknowledging that the Local Board shall oversee quality programs at the Hospitals. *FF32-33*

PMH aligns its hospitals and physician networks under a model called CRC. CRC provides for clinical integration of hospitals, physicians and community providers with health plans and other payers through value driven and risk-based reimbursement systems. The CRC model is intended to improve quality, efficiency and financial performance while providing its patients with quality, affordable healthcare. *FF15* ECHN believes that PMH's CRC model will help overcome the challenges in retaining and recruiting physicians that it has faced in recent years. PMH has developed significant experience in other markets regarding ways hospitals can attract more primary care providers and improve access to care. Recently, PMH succeeded in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners participating in PMH's Rhode Island physician network at the end of 2015, only 18 were employed by the CharterCare System when PMH acquired its two hospitals in mid-2014. *FF48* In order to implement the CRC strategy, PMH has established an IPA entity in Connecticut (Prospect Provider Group CT-ECHN, LLC, or "PPGCTE") and a preferred provider network/health system risk taking entity, Prospect Health Services, CT, Inc., that will contract with payers on behalf of PPGCTE physicians. These two organizations, through management services agreements with PMH, will manage physician participation, risk contracting and care management activities for participating members. *FF49* The goal of the CRC model is to reduce the overall cost of health care by increasing preventive care and early readmissions, reducing inpatient utilization and reducing emergency room visits. PMH will achieve these goals by developing a healthcare delivery network encompassing the entire continuum of patient care, including inpatient

services, home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health related services. *FF50* PMH has demonstrated the efficacy of the CRC model in Southern California, Texas and Rhode Island. In these regions, PMH has improved clinical outcomes, increased quality scores, increased patient satisfaction, reduced readmission rates, reduced average lengths of stay, and reduced medical-cost ratios. For example, from 2012 to 2014 in California and Texas where PMH participates in HMO contracts for seniors, PMH reduced hospital bed days per thousand patients from 1,260 to 720. Additionally, length of hospital stay for this population has been reduced from 5.1 to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. The CRC model has also enabled PMH to attract more primary care providers and has improved access to care. *FF51* The CRC approach not only benefits the patient population through better care and outcomes, but also from a cost perspective. PMH expects its approach to population management services to harness the efficiencies of facilities to enhance care at lower costs. It is anticipated that these cost savings will be passed on to consumers. Consequently, the Applicants have demonstrated that PMH will continue to offer access to high quality services in the same manner that ECHN has been providing them.

In 2013, MMH and RGH collaborated to conduct a CHNA, which identified the current and future health care needs of the community. The four priority health needs identified were heart disease incidence, cancer incidence, diabetes incidence, and arthritis incidence. An implementation plan was developed to respond to the identified health needs. *FF56* PMH and its affiliates will support the priority needs identified by the CHNA with physician alignment and population health management strategies, enhanced through implementation of the CRC, which focuses on the health of vulnerable populations. PMH has committed to implement and support the current CHNA through 2016 and conduct another CHNA for the Service Area over the next two years and to implement the recommendations of such study as deemed necessary and appropriate. *FF57* PMH and ECHN representatives met with leadership for Connecticut's Medicaid Program at DSS and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. PMH is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state. In addition, PMH will actively work with other providers in the community such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the Service Area, including Medicaid recipients. *FF59* The patient populations currently served by the Hospitals is not expected to change as a result of the Asset Purchase. PMH will accept all existing contracts with payers and will complete a Change of Ownership process with commercial payers, as well as Medicare and the Connecticut Medical Assistance Program (Medicaid). *FF60* Based upon the aforementioned, the Applicants have satisfactorily identified a clear public need for the proposed asset purchase and demonstrated how the proposed asset purchase could satisfy the need.

PMH's acquisitions of other health systems and hospitals have resulted in improved financial performance at many of the systems. PMH will bring to ECHN its operational efficiencies and economies of scale that will help to reduce ECHN's expenses. ECHN will be able to participate in PMH's purchasing power, supply chain benefits, employee benefits savings and streamlined revenue collection. PMH also makes available to its hospitals subject matter consultants who are employed by PMH, saving its hospitals the cost of hiring consultants in those areas. *FF62* This proposal will lead to a stronger and more financially secure ECHN. As the financial strength of Connecticut's hospitals significantly contributes to the financial strength of the state's entire health care system, this proposal will improve the financial strength of the state of Connecticut's health care system.

In its audited financial statements for FY 2015, PMH reported total revenues of over $1.3 billion from its operations on a consolidated basis. As of fiscal year end 2015, PMH reported free cash flow of over $112 million. The company also received credit upgrades by both Moody's and S&P in 2015 with Moody's rating PMH's bonds as B1, while S&P rates PMH's bonds as B. *FF18* PMH's financial resources and access to capital are anticipated to maintain ECHN's assets as economically viable and vibrant parts of the healthcare system in Eastern Connecticut by permitting capital investments, better preparing MMH and RGH to participate in new value-based delivery models, offering enhanced practice options for physicians, strengthening its network of providers and allowing for other improvements in operations.

Based upon the aforementioned discussion of the evidence provided by the Applicants in this matter, the Applicants have satisfactorily demonstrated that PMH has made a commitment to provide health care to the uninsured and the underinsured; safeguard procedures are in place to avoid a conflict of interest in patient referral; and certificate of need authorization is justified in accordance with the principles and guidelines set forth in Connecticut General Statutes § 19a-639; those being, access to healthcare services, quality of the healthcare services, public need for the proposed project, and the financial feasibility of the proposed project.

Order

Based upon the foregoing Findings of Fact and Discussion, I respectfully recommend that the Applicants' request for the sale of substantially all of the assets of ECHN and its controlled affiliates to PMH or one or more affiliates of PMH be **Approved** under Conn. Gen. Stat. §§ 19a-486 and 19a-639 subject to the enumerated conditions (the "Conditions") set forth below.

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns, regardless of whether New ECHN, remains the parent company and sole shareholder of the New MMH and New RGH. OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, including, but not limited to, Conn. Gen. Stat. § 19a-486g and the right to impose and collect a civil penalty under Conn. Gen. Stat. § 19a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. Within twenty (20) days following the date of OHCA's Final Decision in this matter (the "Decision Date"), Applicants shall submit schedules to OHCA setting forth each of MMH's and RGH's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the Decision Date and publish this same information on the applicable websites of each Hospital. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(8) & (11); FF 18, 26- 27*

2. Within twenty (20) days following the Decision Date, Applicants shall identify and provide the Certificates of Incorporation for the PMH affiliated entities that shall directly own, operate and hold the hospital licenses of the New MMH and New RGH, respectively, post-closing. These entities shall be duly organized and validly existing under the laws of Connecticut and New ECHN shall be their parent company and sole shareholder as proposed in the CON application. OHCA is imposing this condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(8) & (11); FF 18, 26- 27*

3. Applicants shall notify OHCA in writing of the Closing Date of the Asset Purchase authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:

    a. the APA, including any and all attachments thereto, except that redaction of certain information that may be Trade Secret as defined in Conn. Gen. Stat. § 1-210(b)(5) is allowed for purposes of this filing and placement in the public record; and

    b. Bylaws or similar governance documents for New ECHN, as well as for New MMH and New RGH.

If the Applicants redact material as Trade Secret from the document required by 3.a. above, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be Trade Secret for public record purposes.

OHCA is imposing this condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a) & 19a-613(b); FF 12*

4. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement ECHN's current Community Health Needs Assessment ("CHNA") and for conducting the New Hospitals' next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following:

   (i) the data that will be collected and analyzed to systematically assess health status Indicators of the Service Area;
   (ii) the identity of key community stakeholders and health organizations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation;
   (iii) the qualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined;
   (iv) the frequency with which the Study will be repeated;
   (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the community; and
   (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospitals.

   OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*

5. PMH shall participate with New ECHN and the New Hospitals, and the key community stakeholders and health organizations identified pursuant to Stipulation #4, in conducting the initial Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. The PMH and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/hct2020/hct2020_state_hlth_impv_032514.pdf) as well as any applicable community

health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on the website pages of New MMH and New RGH. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement ECHN's current CHNA for MMH and RGH. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*

6. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospitals for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*

7. Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New MMH or New RGH specific to those services that existed at each of the Hospitals as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospitals. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*

8. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the $75 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and

    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill the Capital Commitment.

The reports shall be signed by PMH's Chief Financial Officer. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 38-45*

9. For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for New ECHN, New MMH and New RGH, respectively:

a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category for the semi-annual period; and

2. the effect of these cost savings on the clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*

10. For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New ECHN, New MMH and New RGH, respectively. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report:

Financial Measurement/Indicators

A. Operating Performance
1. Operating Margin
2. Non-Operating Margin
3. Total Margin
B. Liquidity
1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period
C. Leverage and Capital Structure
1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt
4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. Equity Financing Ratio
D. Additional Statistics
1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*

11. PMH shall maintain and adhere to ECHN's current policies regarding charity care, indigent care and community volunteer services at New MMH and New RGH after the Closing Date or adopt other policies that are at least as generous and benevolent to the community as ECHN's current policies. These policies shall be posted on the website pages of the New MMH and New RGH, respectively, and as additionally required by applicable law. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

12. For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of New MMH and New RGH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website pages of the New Hospitals simultaneously with their submission to OHCA. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

13. PMH shall maintain current community benefit programs and community building activities for New MMH and New RGH for three (3) years after the Closing Date as identified in the MMH and RGH most recent Schedule H of IRS Form 990 and PMH shall apply a 1% increase per year toward community building activities in terms of dollars spent.
In determining the New MMH and New RGH participation in and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.
    a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

14. New MMH and New RGH agree to comply with the following general community benefit standards for at least the first three years. (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusions of other qualified doctors; (c) the New Hospitals shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24/7 emergency departments and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); Tr., Testimony of Tom Reardon, President. PMH East on 5/3/16, pp. 103-04*

15. New MMH and New RGH shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations. Specifically, New MMH and New RGH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, New MMH and New RGH shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, New MMH and New RGH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition so as to ensure continued access to health care services to the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

16. Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who has experience in hospital administration and regulation, including maintaining quality control in a High Reliability Organization ("HRO"). The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing Date, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to New Hospitals and their applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*

17. The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of New Hospitals on no less than a semi-annual basis to assess PMH's modified Quality Assurance Performance Improvement ("QAPI") program, each facility's efforts to remain an HRO, and compliance with the Quality Commitment Letter and such other matters as OHCA and/or FLIS shall deem pertinent. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this

condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*

18. If the New Hospitals' Local Board agrees with PMH to change any of the Seller Quality Programs described in the Quality Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated by a governmental agency, PMH shall notify OHCA and the Health Systems Branch in writing at least thirty (30) days prior to any such change going into effect. If the Independent Monitor disagrees with the change, OHCA may require that a request for modification be submitted and approved as required by C.G.S. §4-18la to make the change. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*

19. For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals' activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

20. For three (3) years following the Closing Date, PMH shall allow for two (2) community ombudsman to serve as ex-officio, non-voting members of the New MMH and New RGH Local Board. The community ombudsman shall be selected in a way that OHCA and PMH shall mutually agree in writing will result in the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

21. PMH, New ECHN, New MMH and New RGH shall abide by all requirements of licensure that may be imposed by DPH's Health Systems Branch (HSB) in any Pre-Licensing Consent Order or similar agreement that HSB may enter with these parties. OHCA is imposing this condition to ensure that quality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 30-37*

Based upon the foregoing, I respectfully recommend that the CON application for the transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc. be approved.

5/25/16
Date

Kevin Hansted, Esq.
Hearing Officer