Responses to Deficiencies
Dated November 13, 2014

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Tenet Healthcare Corporation and
Yale-New Haven Health Services Corporation

OHCA Docket Number: 14-31926-486 and
Attorney General Docket Number: 14-486-01

November 25, 2014

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November 25, 2014

VIA HAND-DELIVERY

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

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

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation
OHCA Docket Number: 14-31926-486 and Attorney General Docket Number: 14-486-01

Dear Attorney General Jepsen and Commissioner Mullen:

Eastern Connecticut Health Network, Inc., Tenet Healthcare Corporation, and Yale-New Haven Health Services Corporation (collectively, the "***Applicants***") hereby submit responses to the questions issued by the Office of the Attorney General and the Office of Health Care Access by letter dated November 13, 2014.

At your request, two (2) hard copies and one (1) electronic copy have been provided to the Office of the Attorney General, to the attention of Gary W. Hawes, Assistant Attorney General. Seven (7) hard copies and three (3) electronic copies have been provided to the Office of Health Care Access, to the attention of Steven W. Lazarus, Health Care Analyst.

The Applicants thank you and your staff for your time and consideration in connection with this process. If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326.

Sincerely,

Wiggin and Dana LLP

By ______________________
Rebecca A. Matthews
Its Partner

By ______________________
Melinda A. Agsten
Its Partner

cc: Steven W. Lazarus, Office of Health Care Access
Gary W. Hawes, Assistant Attorney General
Dennis P. McConville, Senior Vice President for Planning, Marketing, and Communications, ECHN
Joyce Tichy, Esq., General Counsel, ECHN
Gayle Capozzalo, Executive Vice President, Strategy & System Development, YNHHSC
William J. Aseltyne, Senior Vice President & General Counsel, YNHHSC
Trip Pilgrim, Senior Vice President of Development, Tenet
Jeffrey Peterson, Senior Counsel, Tenet
Collin P. Baron, Esq., Pullman & Comley, LLC

1. Please provide draft copies of the Certificate of Incorporation and the Bylaws for the proposed Conversion Foundation.

   Response:

   Draft copies of the Certificate of Incorporation and the Bylaws for the proposed Conversion Foundation are provided in Exhibit I. Please note that the documents are working drafts and are therefore subject to revision and completion.

2. Please provide a draft of Schedule 2.02(n), the listing of the assets of the ECHN Community Healthcare Foundation, Inc., to the extent the list is not duplicative of your Exhibits 17, 18, and 19 to the Application.

   Response:

   A draft Balance Sheet listing all the assets of the ECHN Community Healthcare Foundation, Inc. (the "ECHN Foundation") as of September 30, 2014, is provided in Exhibit II. The list of assets includes the following ECHN Foundation assets that were not included on Exhibits 17, 18 or 19:

   - **Cash and cash equivalents;**
   - **Amounts due from affiliated entities;**
   - **Prepaid expenses;**
   - **Pledges receivable;**
   - **Fully expendable funds subject to donor imposed use restrictions (special purpose funds) that ECHN believes will be spent in full prior to the Closing; and**
   - **Board designated funds.**

   These assets are included in the total assets shown on Exhibit II and are also broken out and reported in a separate column of the Exhibit. The Exhibit also includes a column breaking out the assets that were reported on Exhibits 17 (endowment) and 18 (special purpose funds) (per the answer to Question 11 of the Application, Exhibit 18 reported only the special purpose funds that ECHN believed would not be spent in full prior to the Closing). Please note that Exhibit 19 relates to trusts held by outside trustees and did not report any funds held by the ECHN Foundation.

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

Response:

A financial analysis (balance sheet) of the proposed transaction as outlined above has been provided in Exhibit III. It is important to note this analysis is based upon the unaudited September 30, 2014 balance sheet. To the extent that the balance sheet changes between September 30, 2014 and the Closing, the net proceeds analysis will also change.

4. Page 19 of the Application and section 5.18, Capital Commitment, of the Asset Purchase Agreement ("APA"), pages 180-181, states that VHS Eastern CT will continue to operate both MMH and RGH as acute care hospitals for at least three years. Applicants also state on page 53 of the Application that "ECHN, Tenet and YNHHS are committed to ensuring the long-term future and viability of MMH and RGH." Please reconcile these two statements. In responding to this question, please answer the following:

   a. Why is the commitment period to operate both hospitals as acute care hospitals limited to three years?

      Response:

      Pursuant to Section 5.15 of the APA, VHS Eastern CT has agreed, for a period of at least three (3) years after closing, to (i) continue operating the Hospitals in their current locations as acute care hospitals with emergency departments, and (ii) maintain an ownership interest in Seller's current post-acute care continuum of care network and require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for such three-year period. Accordingly, the contractual commitment is far more than a commitment to simply operate both Hospitals as acute-care hospitals for a specified period. In addition, the reference to VHS Eastern CT's commitment as merely a three year commitment is misleading. The three year period in the APA was a negotiated provision between the parties. Tenet and YNHHS have no current intent to discontinue the operation of either Hospital. In fact, Tenet has committed to spend $75 million of capital over *five* years for capital improvements, to upgrade the facilities, and to recruit physicians to the areas served by the Hospitals. Tenet and YNHHS are investing significant time and resources to build a clinically integrated network that will benefit both Hospitals. Tenet and YNHHS are committed to ensuring the long-term future of both Hospitals and fully expect that the capital commitment, the enhanced physician recruiting and retention, supply chain savings, operational expertise, implementation of best practices and service line extensions will enhance the health of both Hospitals and ensure their long-term viability.

Tenet, YNHHS and ECHN believe that, based on the financial condition of the Hospitals, they have a far stronger likelihood of continued operations under the ownership of Tenet and YNHHS than they have under the current structure.

b. What performance criteria/financial metrics will be used to determine whether one or both of MMH and RGH will continue or cease operations beyond this three-year period?

Response:

As stated above, the three-year period in no way reflects VHS Eastern CT's intention with respect to the operation of the Hospitals. As such, there are no performance criteria or financial metrics contemplated that would determine whether operations would be discontinued. After the closing, VHS Eastern CT will continually review the needs of each community and the quality of the care that is being delivered, in the same manner as at all hospitals operated by Tenet. It is important to recognize that with a $105 million purchase price and a $75 million capital commitment, Tenet will be making a significant investment with the expectation that it will improve the quality of care, scope of services and financial performance of MMH and RGH. It has no plans to cease operations, and in fact intends to expand the scope and quality of services available. Tenet, YNHHS and ECHN believe that, based on the financial condition of MMH and RGH, they have a far stronger likelihood of continued operations under the ownership of Tenet and YNHHS than they do under the current structure.

c. Discuss all previous closures or relocations of acute care hospitals undertaken by Tenet, the dates of such closures or relocations, and the factors that led to the decision to close or relocate the hospital?

Response:

Closures

Over recent years, inpatient utilization has declined in response to changing healthcare services, technological advancements, and trends in managed care. Along with such changes, the need for inpatient hospital beds has also declined. Almost all hospitals closed by Tenet have been those with low occupancy in urban areas where patients had easy access to other acute care hospitals. These included:

Hospital Name	Location	Year Closed
Pioneer Hospital(1)	Artesia, CA	1997
Harbor View Medical Center	San Diego, CA	1997
Woodruff Community Hospital	Long Beach, CA	1997
North Hollywood Medical Center	North Hollywood, CA	1998
Westside Hospital	Los Angeles, CA	1998

Hospital Name	Location	Year Closed
St. Luke Medical Center	Pasadena, CA	2002
Santa Ana Hospital Medical Center	Santa Ana, CA	2003
Florida Medical Center South	Plantation, FL	1998
Jo Ellen Smith Medical Center	New Orleans, LA	1999
Compton Heights Hospital	St. Louis, MO	2000
City Avenue Hospital	Philadelphia, PA	2000
Parkview Hospital	Philadelphia, PA	2003

(1) Pioneer Hospital was acquired as part of a network development arrangement with MedPartners. Inpatient services were closed at the time of the acquisition, with acute care services provided at other Tenet hospitals in the Los Angeles area.

Other hospitals have closed in special or extenuating circumstances:

- **Valley Community Hospital in Santa Maria, CA, was closed in 1999 when the facility was sold to Catholic Healthcare West. It is now operated as an outpatient campus of Marian Medical Center, less than two miles away.**

- **Memorial Medical Center and Lindy Boggs Medical Center in New Orleans, LA, closed in 2005 after sustaining heavy damage in Hurricane Katrina.**

- **Frye Regional Medical Center's Alexander Campus in Taylorville, NC, was closed in 2007. This was a critical access hospital, and at the time of closure the average inpatient census was less than four, consisting largely of non-acute "swing bed" patients.**

- **The Detroit Medical Center Surgery Hospital in Madison Heights, MI was closed after sustaining extensive damage from a flood in August 2014. It has not yet been determined whether the hospital will reopen.**

- **Phoenix Memorial Hospital was closed in 2007 and later converted into a Long Term Acute Care facility. Note that Tenet acquired this hospital out of bankruptcy as a part of larger transaction that also included a health plan and land, where Tenet committed to construct a new hospital. The new hospital, West Valley Hospital, opened in 2003.**

<u>Relocations</u>

- **In 2010, East Cooper Medical Center in Mount Pleasant, SC was relocated to a new facility less than one mile from the old campus.**

- **In 2011, Southeast Baptist Hospital in San Antonio, TX was renamed Mission Trail Baptist Hospital and relocated to a new facility within five miles.**

d. Have any of the Applicants studied the impact on health care delivery in the service area if either MMH or RGH were to cease operations as an acute care hospital and, if so, what were the results of that study?

Response:

Tenet and YNHHS do not purchase health systems to close them or to reduce the scope of services offered to local residents. ECHN, Tenet and YNHHS believe that both MMH and RGH are valuable assets to the delivery of care for area residents. The Applicants have not, therefore, studied the impact on health care delivery in the service area that could result from ceasing acute care operations at either MMH or RGH. The primary goals for affiliation established by ECHN included (i) to attract patients and providers based on quality, service, accessibility and affordability, and (ii) to be the provider of choice east of the Connecticut River providing a full spectrum of services. Those goals foresee the continued provision of acute care services at both MMH and RGH, so no studies were contemplated or pursued by the Applicants related to a closure of either acute care hospital.

e. Is one of the ECHN hospitals more vulnerable to closure after the three-year period than the other and, if so, which one?

Response:

ECHN, Tenet and YNHHS do not believe that either hospital is vulnerable to closure after the three-year period. Continued reductions in payments for services, a continuation of the Connecticut Hospital Net Patient Revenue Tax and the reform of payment systems will present significant challenges for ECHN that will be mitigated with approval of this transaction. The ability to reduce the non-salary expense base due to economic scale that Tenet will bring, enhance service offerings through the clinical resources that YNHHS will provide, and the availability of capital resources to invest in technology, programs and facilities are not possible if ECHN remains independent.

f. Please provide a detailed explanation for the answer to subsection (e) above.

Response:

While healthcare reform is expected to result in more investments to develop ambulatory care sites and a continued shift to more care being offered on an outpatient basis, the need for local access to acute care inpatient services will remain. The communities that RGH and MMH serve have enough demand for acute care services to support both acute care hospitals. Having capital and clinical resources available from Tenet and YNHHS to invest in technology and clinical programs that address identified health care needs and attract physicians to practice at ECHN will ensure that both hospitals continue to offer acute care

services needed in the community. With this added investment in technology and clinical programs, patients will have increased access to more comprehensive care in their own communities, reducing the need for them to travel longer distances to receive the same levels of care.

Hospitals like MMH and RGH that offer lower cost care while providing quality outcomes will be attractive to both patients and referring physicians. If the proposed Asset Purchase is approved, the Applicants expect access to low cost, high quality care in the local communities around MMH and RGH will improve, resulting in an increase in the overall number of patients that seek care from MMH and RGH. The anticipated volume growth, despite the emergence of new payment models, will help to ensure the long-term financial viability of MMH and RGH. ECHN's acquisition by Tenet and YNHHS will provide the necessary capital and clinical resources necessary for MMH and RGH to overcome the financial challenges expected in a risk-based payment system and continue to be viable institutions offering acute care services.

5. On pages 19 and 26 of the Application, Applicants state that VHS Eastern CT will pay $105 million for the assets of ECHN, subject to adjustments that will include net working capital reconciliation. On page 106 of the Application, the Applicants indicated that the Buyer intends to pay $135 million to ECHN as full consideration for the assets minus the net working capital as of the closing date for the Asset Purchase ("Closing Date"). On page 621, Exhibit 13, the Applicants indicated that the initial agreement envisioned a purchase price of $135 million, but the amount was subsequently revised to $105 million after completion of financial due diligence by the Buyer. Provide a detailed description of the factors that reduced the purchase price by $30 million. Include a list of the items, if any, eliminated from the proposed Asset Purchase that resulted from this process.

   Response:

   The change in the price did not relate to any eliminated items from the Asset Purchase. When Tenet offered a purchase price of $135 million, ECHN's pension liability was more than $35 million higher than it is currently. Additionally, during the due diligence process, reimbursement reductions related to the wage index and the reduction in state payments were identified, which result in a material decline in ECHN's operating performance compared to the time of the original offer. As a result of these facts, Tenet and ECHN agreed to an adjustment of the purchase price.

6. How will the commitment by VHS Eastern CT to spend $75,000,000 on capital items over 5 years be impacted or influenced by the shorter 3-year commitment with respect to the

continued operation of MMH and RGH as acute care hospitals? In responding to this question please also answer the following:

Response:

The commitment by VHS Eastern CT to spend $75,000,000 on capital items over 5 years will not be impacted or influenced by the shorter 3-year guarantee with respect to the continued operation of MMH and RGH as acute care hospitals. The spending for capital items will be directed at program growth, primary care access and ambulatory growth based on identified health needs and opportunities to address those needs. The capital will be allocated to technology, equipment, facilities and infrastructure upgrade and replacements. Potential investments will be prioritized across care settings based on established criteria and, since no studies analyzing the impact of closing one of the hospitals has been performed or is planned, prioritization of investments will consider capital investments at both hospital campuses, in addition to Woodlake at Tolland and other ambulatory locations.

a. Will spending for capital items at either hospital be impacted by an assessment period to determine the hospitaløs viability?

   Response:

   As reflected in the answer to Question 4(a), the contractual commitment to maintain the Hospitals' operations is unrelated to VHS Eastern CT's intent with respect to these facilities and will not impact the $75 million capital commitment.

b. Which projects on the list of priority capital projects in terms of medical equipment and information technology as well as construction and renovation set forth at page 82 of the Application are expected to be carried out within the first year following the õClosing Dateö?

   Response:

   It is expected that the upgrades to the emergency department at MMH to address the needs of patients with behavioral health conditions will be underway at closing as they are budgeted for fiscal year 2015. The remaining items on the list included on page 82 of the Application were developed by ECHN's senior management team. Those items will be considered for a capital plan subject to the completion of a planning process with participation by the to-be-formed Local Board and VHS Eastern CT after closing the transaction. The timing of the capital investments will be set in that capital plan. Therefore, with the exception of the emergency department upgrades which are expected to be underway at the time of the closing, the Applicants cannot determine which of

the expected projects will be included in the capital plan or the timing for implementation of specific projects.

c. Which projects on the list are expected to be carried out within the first three years following the Closing Date?

Response:

The list of capital investments and the timing of those capital investments will be developed by the Local Board and VHS Eastern CT as referenced in the response to 6(b) above. Until the Local Board has been formed and has had an opportunity to participate in the planning process, the Applicants cannot determine which projects will be included in the capital plan or the timing for implementation of specific projects.

7. Please confirm whether it is the Applicantsø intention to appoint separate Chief Executive Officers for each of MMH and RGH post-closing and, if so, why this is being done?

Response:

It is not the Applicants' intention to appoint separate Chief Executive Officers (CEO) for each of MMH and RGH post-closing. There will be one CEO.

8. Reference is made to page 23 of the Application and the description of the governance of the Tenet/YNHHS joint venture Regional Provider Organization ("RPO"), and the reference to the approval rights of YNHHS related to material decisions. These approval rights have been previously represented to the OAG and OHCA to cover the following actions by the RPO and its subsidiary healthcare facilities (of which VHS Eastern CT would be one): (i) acquisition of a healthcare facility by the RPO; (ii) a joint venture or major service line agreement between a healthcare facility that is owned by the RPO and a healthcare facility that is not owned by the RPO; (iii) the merger of a healthcare facility that is owned by the RPO with a healthcare facility that is not owned by the RPO; (iv) a transfer or affiliation agreement between a healthcare facility that is owned by the RPO and any tertiary hospital that is not owned by the RPO; (v) an academic affiliation between a healthcare facility that is owned by the RPO with an academic institution other than the Yale School of Medicine or a similarly accredited institution subject to certain conditions; (vi) the admission of a new member to the RPO; (vii) a management services agreement or an amendment thereto between Tenet and a healthcare facility owned by the RPO; (viii) any contract between the RPO or a healthcare facility owned by the RPO with Tenet or an affiliate that is not made in the ordinary course of business and on commercially reasonable terms; and (ix) any

outsourcing of any major service line by a healthcare facility owned by the RPO to a healthcare facility not owned by the RPO. With respect to these approval rights, please answer the following.

a. What is the nature of YNHHS' approval rights (i.e., are they reserved powers or another form of governance right)?

Response:

The approval rights of YNHHS cited in Question 8 would be a contractual right granted by contract to YNHHS. It is anticipated that those contractual approval rights will be incorporated into the RPO operating agreement once it is drafted.

b. If YNHHS does not grant its approval to an action described above, but a majority of the seven-member Board of Managers of the RPO favors the action, can the RPO undertake the action?

Response:

If YNHHS does not grant its approval to any action described in the body of Question 8, the RPO may not undertake the action. It is anticipated, however, that the operating agreement of the RPO will provide a dispute resolution mechanism if the Board of Managers of the RPO favors an action that YNHHS does not approve. In addition, in the event that YNHHS does not approve the RPO's acquisition of a healthcare facility, Tenet may acquire the facility on its own.

c. If the answer to the question is subsection (b) is yes, please describe the governance processes that would permit the RPO to undertake the action.

Response:

As noted in the preceding question, except where determined otherwise as a result of an agreed upon dispute resolution methodology, the RPO may not undertake any of the actions listed that YNHHS does not approve.

d. If the answer to the question in subsection (b) is no, please describe the protections that are in place to prevent YNHHS from acting in a manner that could create a conflict of interest for YNHHS between the hospitals and health systems in which it has 100% ownership and the hospitals and health systems owned and controlled by the RPO in which YNHHS would have a 20% ownership interest.

Response:

Tenet is satisfied that none of the actions for which YNHHS approval would be required create a conflict of interest for YNHHS between the hospitals and health systems in which it has a 100% ownership, on the one hand, and the hospitals and

health systems owned and controlled by the RPO in which YNHHS has a 20% ownership interest, on the other hand. Tenet and YNHHS believe that the 20% ownership interest of YNHHS in the RPO aligns the interests of Tenet and YNHHS, which is why the parties chose a joint venture structure as opposed to a mere contractual arrangement. Tenet believes that YNHHS is invaluable to the RPO joint venture for a variety of reasons including its name and reputation as a world class academic medical center, its clinical expertise, its clinical service lines, its brand, its ability to assist in physician recruiting and retention, its clinical protocols and its subspecialty practices. Tenet believes that YNHHS, as the preeminent health system in the region, is an invaluable partner and Tenet gave careful consideration before agreeing to the YNHHS approval rights, which Tenet does not believe will create a conflict. Both Tenet and YNHHS have the same goal—to make all health systems that are part of the RPO centers of excellence where high quality, low cost care will be provided locally.

9. In reference to the statement related to capital commitment on page 27, "VHS Eastern CT has the right to defer this commitment beyond a five-year period if the State of Connecticut enacts any legal requirements after closing that discriminate against for profit hospitals and cause the Hospital Businesses to suffer a decline in EBITDA of more than ten percent in any year on a consolidated basis." Please identify any legal requirements connected with Tenet's operations in other markets that Tenet has considered to be discriminatory against for-profit hospitals and describe the financial consequences of such legal requirements.

   Response:

   To date, there are no legal requirements enacted that Tenet considers to be discriminatory against for-profit hospitals.

10. On page 28 of the Application and section 5.17 of the APA (Educational Support), page 180, the Applicants state that the "Buyer agrees to maintain and support financially the University of New England medical student and other health professions teaching programs established by Seller, in addition to Seller's graduate medical education programs, while operating at a level to not exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by CMS." Please explain the meaning of the statement "while operating at a level to not exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be establish by CMS" and how this condition to continued financial support impacts the growth of ECHN's medical education programs in the future. Please also describe:

Response:

To address the need for primary care physicians in eastern Connecticut, ECHN committed to a major strategic initiative to develop a medical school affiliation and a Family Medicine Residency Program. In 2010, the medical school program was introduced and in 2013 the residency program began, with the first group of residents arriving in July of that year. Inclusion of the provision referenced Section 5.17 of the APA directly reflects VHS Eastern CT's intent to support the medical student and medical resident education programs at ECHN.

Federal Regulations administered by CMS establish a funding "cap" for the total number of residency positions for which they will reimburse training programs. The regulations allow a new program a total of five years from program initiation to reach the cap. The Family Medicine Residency Program accepted its initial class of residents on July 1, 2013, so its cap will be implemented in 2018. This means that CMS will only fund residency training slots up to the cap limit after 2018. ECHN's plan since the inception of the program was to accept residents only up to the cap limit. The language in the APA supports this plan and has no material effect on the growth of the program.

a. All health profession teaching programs established by ECHN;

   Response:

   Please see Exhibit IV for a listing of the health profession teaching programs supported by ECHN.

b. What affiliations, if any, currently exist between the Yale School of Medicine ("YSM") and MMH and RGH, respectively;

   Response:

   There are no current affiliations between YSM and MMH and RGH.

c. What affiliations between MMH and RGH, on the one hand, and YSM, on the other hand, are planned if the Asset Purchase is approved;

   Response:

   There are no plans for affiliations for MMH and RGH with YSM if the Asset Purchase is approved. If the Asset Purchase is approved, the future MMH and RGH will become network participants of YNHHS, a separate entity from YSM.

d. If applicable, how ECHN's relationship with the teaching programs of University of New England - College of Osteopathic Medicine (UNECOM) and its Family Practice Residency Program will co-exist with its affiliations with YSM; and

Response:

This question is not applicable as there are no plans for MMH and RGH to pursue an affiliation with YSM.

e. The nature of any planned affiliation between YSM and the hospitals owned and controlled by the RPO.

Response:

There are no plans for an affiliation between YSM and the hospitals owned and controlled by the RPO.

11. On page 28 of the Application and section 5.16 of the APA, page 180, the Applicants state that "VHS Eastern CT will also ensure that each Hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopts other policies that are at least as favorable to the community as ECHN's current policies)." With respect to this statement please address the following:

a. ECHN's Financial Assistance and Charity Care Policy appear to cap eligibility for uncompensated care at 250% of the federal poverty limit ("FPL"). Are uninsured and underinsured patients with incomes above 250% to 400% of the FPL eligible to receive uncompensated care or other financial assistance?

Response:

ECHN currently provides charity care or other financial assistance for patients with incomes between 250% and 400% of the FPL. Please refer to the response to question 11(d).

The other benefits that ECHN currently provides, but are not addressed in the charity care policy are:

- **Any/all uninsured patients receive a 30% discount off of charges at time of billing. This happens regardless of any charity care or financial assistance application.**
- **Medicaid eligibility: Whether or not a patient is applying for Financial Assistance, any patients identified as potentially being eligible for Medicaid are offered assistance in completing the Medicaid application.**

b. How many Tenet hospitals limit financial assistance and charity care at 250% of the FPL?

Response:

No Tenet hospital limits financial assistance and charity care to patients at 250% of the FPL. Tenet's Charity Care policy, included as Exhibit V, allows a patient with income between 200% and 300% of the FPL to receive charity care if the patient meets certain thresholds for gross annual income and total billed charges. Because of these limitations as compared to ECHN's policy, it was determined that the ECHN Charity Care policy is more favorable to the community and will be adopted by VHS Eastern CT.

c. What are the plans of the RPO to standardize charity care policies across the hospitals that it seeks to control and, if such standardized policies are planned, is the RPO committed to implementing the charity care policy of the hospital with the most generous policy across the network?

Response:

The RPO has no plans to standardize charity care policies for hospitals that it owns and operates. In each of the four pending health system transactions, Tenet (on behalf of the to-be-formed RPO) has committed to adopting and implementing each hospitals' legacy charity care policies as they are more favorable to their communities than Tenet's Charity Care policy.

d. Please provide any policies and procedures of ECHN regarding indigent care, community volunteer services and community benefits.

Response:

Policies and procedures of ECHN for Financial Assistance/Charity Care are attached as Exhibit VI.

12. On page 32 of the Application, the Applicants indicated that in the first half of fiscal year 2012, with the implementation of health insurance exchanges pending, ECHN began to model pro forma projections for the next five years. Please provide a contemporaneous copy of this pro forma and the assumptions associated with the projections. Also, please provide a calculation showing each element of the projected $7.5 million in decreased funding projected for FY 2015 that is referenced on page 83 of the Application.

Response:

In the early part of fiscal year 2012, ECHN developed a five-year pro forma that measured the potential impact of the new Health Insurance Exchanges (HIEs) on operations. A copy of the pro forma Income Statement reflecting the projected HIE impact developed in the fall of FY 2012 has been provided as Exhibit VII.

In developing the pro forma, ECHN incorporated the following assumptions based on then-current industry understandings about the effect that HIEs would have on the health care market:

- **That given Connecticut's relatively high rate of insurance coverage throughout the population a relatively small percentage of previously uninsured patients in ECHN's market would be newly covered by HIEs.**
- **That in ECHN's market approximately five percent of managed care patients would shift to plans offered through the HIEs.**
- **That reimbursement under the HIE plans would be at rates similar to existing government-sponsored programs, which are significantly lower than the rates paid by managed care payers, thus resulting in an overall decrease in reimbursement for patients moving to the HIEs.**
- **That volume growth would remain flat.**
- **That average managed care rates would increase 7% per year.**
- **That government payor rates and reimbursement would remain constant.**

The HIEs are part of national healthcare reform efforts to provide low cost insurance options for patients without insurance. However, because Connecticut already had a relatively low uninsured rate in 2012, with only 9% uninsured in Connecticut[1] versus 15.4% nationwide[2], ECHN assumed in developing the pro forma that increased insurance coverage for the previously uninsured patient population would be relatively limited, and would not compensate for the anticipated shift of patients with employer coverage to the HIEs[3]. The anticipated decrease in the uninsured rate and the anticipated shift from managed care payers to the HIE were factored into the last two years of the pro forma in fiscal years 2014 and 2015. The HIE impact on the hospitals' revenues was estimated by applying the Medicare and Medicaid reimbursement rates to cover the cost of care for the hospitals' current self-pay patients. Utilizing the more conservative assumption that reimbursement for the HIE plans would be at the Medicaid rates, the net result was an estimated revenue loss of approximately $11,000,000 each year.

Financial projections without the impact of the HIE were relatively stable through the projection period, with positive operating margins. In actuality, while the evolving impact of HIEs has been slower than anticipated, other pro forma assumptions regarding market conditions appear to have been optimistic. ECHN has been unable to

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[1] United States Census Bureau / U.S. Department of Commerce: American Fact Finder, 2008-2012 American Community Survey 5-year estimates
(source: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF).
[2] Income, Poverty, and Health Insurance Coverage in the United States: 2012; Issued September 2013 by the United States Census Bureau (source http://www.census.gov/prod/2013pubs/p60-245.pdf).
[3] MedAssets Healthcare Business Summit 2012: Medicare Breakeven Leaving No Stone Unturned. April 11, 2012.

achieve targeted managed care rate increases of 7% per year as many payers were and are intent on keeping year-over-year reimbursement rates flat. Furthermore, volumes have declined markedly since 2011.

Most importantly, the 2012 projections did not (and could not) anticipate the most significant and most challenging obstacle to ECHN's financial performance, which was the radical reduction in governmental reimbursement that had only started to materialize late in FY 2011. These continuing annual incremental cuts to Medicare and Medicaid reimbursement, coupled with the implementation of the Hospital Net Patient Revenue Tax, have reduced ECHN's net revenues by $15,000,000 as compared to fiscal year 2010 reimbursement.

This stark decline in government funding is anticipated to continue into the future. In fiscal year 2015, ECHN will be impacted by an additional $7,500,000 decrease in funding as compared to fiscal year 2014, assuming Medicare and Medicaid volumes remain stable, a consistent payer mix, and inpatient volumes in FY 2015 that are similar to the FY 2014 actual performance. A $4,825,000 reduction in Medicare reimbursement, resulting from a change in the Hartford County wage index, and a $2,643,000 reduction in Medicaid reimbursement that went into effect on July 1, 2014 as part of the Hospital Net Patient Revenue Tax are the primary drivers for this projected decrease in funding for FY 2015.

13. Reference is made to page 34 of the Application and the RFP delivered to Vanguard and YNNHS attached at Exhibit 4 to the Application. Based on the terms of the Strategic Alliance Agreement entered into between Tenet and YNHHS and Tenet's and YNHHS' proposed joint venture RPO, please provide answers to the following questions that were posed in the RFP under the headings Vision and Operations or Service Commitments/Enhancements:

    a. Will the medical staffs of MMH and RGH be integrated with those of any other hospital controlled by the RPO or with the medical staff of YNHH? Please provide an explanation for your answer, including the manner in which enhanced clinical care will be provided to the community and shifts in referral patterns that are likely to occur under the medical staff arrangement that will be followed.

    Response:

    The medical staffs of MMH and RGH will remain independent of the medical staffs of the other hospitals controlled by the RPO and the medical staff of YNHH. In partnership with the Regional Risk Organization ("RRO"), the medical staffs of MMH and RGH will strive to achieve a high degree of clinical integration. Additional detail about the clinical integration strategy is included in part (c) of this response. Changes in current referral patterns are not anticipated as a result of MMH and RGH medical staff structures.

b. Please describe the way in which YNHHS, as the clinical partner in the RPO, measures quality and safety and discuss how its hospitals perform in terms of CMS quality indicators and patient satisfaction.

Response:

YNHHS currently measures quality and safety through a variety of metrics as measured by CMS and other national organizations. These measures will continue to be used by YNHHS and the RPO to assess and identify areas for improvement pertaining to quality of care, patient safety and patient satisfaction.

YNHHS' hospitals have performed well in terms of CMS quality indicators and patient satisfaction. This performance is evident through a review of the quality, patient safety and patient satisfaction available on Hospital Compare on the Medicare.gov website. A copy of the most recent results on the Medicare.gov site for YNHH, Bridgeport and Greenwich Hospitals is provided in Exhibit VIII.

c. Please discuss VHS Eastern CT's and the RPO's strategy that will be followed for clinical integration and alignment with employed and independent medical staff members.

Response:

VHS Eastern CT's and the RPO's strategy for clinical integration and alignment with employed and independent medical staff members is encapsulated within the purpose and strategy of the RRO. The RRO will be the vehicle for achieving clinical integration among the employed and independent medical staff members. The purpose of the RRO is to manage increasing levels of risk of enrolled patient populations at participating locations within the service area, including managing risk contracts with Medicare, Medicaid and other third party payers. The business of the RRO will be predicated and conditioned on participating providers achieving a level of clinical integration that is sufficient to enable the assumption of risk of the cost of all or a portion of the provision of care as well as the opportunity to share in all or a portion of savings against specified benchmarks. YNHHS will provide clinical protocols, evidence-based practices and clinical intellectual property to the employed and independent physicians on a service line specific basis.

d. What approach will VHS Eastern CT and the RPO take with respect to medical staffing, and/or facility equipment and enhancements for ECHN with respect to the following services (please provide as many specifics as possible):

Response:

VHS Eastern CT will initiate a planning process with the Local Board and the medical staff to evaluate the needs for and opportunities to address medical staffing and to enhance, expand or introduce clinical programs and services for the towns

served by ECHN. The process will involve a detailed environmental assessment to best understand the health needs and opportunities for the communities currently served by ECHN and plans will be developed based on goals and objectives with identified resource and financial requirements.

i. Enhancing and expanding Primary Care capabilities, in existing and new markets,

Response:

VHS Eastern CT will develop a medical staff development plan that addresses the identified needs to recruit primary care physicians to the communities served by ECHN. They will continue with ECHN's efforts to establish medical homes to address the care of patients with chronic illnesses. VHS Eastern CT will continue to support ECHN's medical school affiliation and a Family Medicine Residency Program post-closing which were introduced to support the development of primary care providers for eastern Connecticut.

ii. Cardiovascular Services, including Diagnostic and Interventional Catheterization, Electrophysiology and Pacemaker Programs,

Response:

Depending upon the needs of the communities served by ECHN, the Yale-New Haven Heart & Vascular Institute, which offers a full spectrum of cardiovascular care on both an inpatient and outpatient basis at YNHH, Bridgeport Hospital and Greenwich Hospital, may extend its services, brand, protocols and standards of care to ECHN.

iii. Cancer Care, including Medical Oncology and specialty Oncologic Surgery,

Response:

The Smilow Cancer Hospital has sites throughout the State and the Applicants will explore with ECHN medical oncologists, radiation oncologists and surgical oncologists opportunities to provide clinical trials, enhance clinical services and provide research opportunities at ECHN.

iv. Maternal Fetal Medicine/Perinatology,

Response:

The Applicants will evaluate the opportunity to expand ECHN's maternity services with the development of a maternal fetal medicine program.

v. Bariatric Surgery,

Response:

The Applicants will evaluate the introduction of a bariatric surgery program and related services for local residents who could benefit from them.

vi. Orthopedics, with an emphasis on Spine Surgery and Joint Replacement Surgery, and

Response:

The Applicants will explore opportunities to enhance the musculoskeletal services currently offered by ECHN.

vii. Pain Management Service/Program.

Response:

ECHN has an interest in establishing a Palliative Care Program. The Applicants will explore opportunities to develop such a program with YNHHS, which has an established Palliative Care Program at each of its hospitals.

e. What are the plans for maintaining or enhancing ECHN's current non-acute programs, such as the skilled nursing and rehabilitation center and the visiting nurse service, as well as joint ventures, such as Tolland Imaging Center, Evergreen Endoscopy Center, Eastern Connecticut PHO, Community Cancer Care and others?

Response:

The Applicants will continue the current efforts of ECHN to promote clinical integration with ECHN's ambulatory and post-acute care partners, affiliates, and joint ventures as well as with its medical staff. To effectively manage the health of populations and to compete in a risk-based payment environment, optimal performance and outcomes are necessary. As stated in response to question 35 in the Application, "to effectively manage a risk based payment system, a complete continuum of care to deliver services at the right place at the right time must be supported with capital investments in information technology and alternative ambulatory sites of care." Health systems will need to consider the entire continuum of care in order to effectively manage patients in this environment.

14. With respect to the post asset purchase organizational chart provided at page 1829 of the Application which depicts the relationship of VHS Eastern CT to its parent, the RPO, please clarify which organization, VHS of Connecticut, LLC or the RPO, will have the 80%, 100% and 100% interest in the VHS Waterbury Health System, VHS Saint Mary's Health System and the Tenet Medical Foundation, Inc., respectively.

Response:

VHS of Connecticut, LLC will have a 100% interest in the Tenet Medical Foundation, Inc., an 80% interest in VHS Waterbury Health System and a 100% interest in VHS Saint Mary's Health System. Post-closing, VHS of Connecticut, LLC will transfer its ownership interest in VHS Waterbury Health System and VHS Saint Mary's Health System to the RPO.

15. Questions 14, 15 and 16 of the Application were each two-part inquires, asking whether: (i) there is a proposed corporate relationship between the New ECHN Hospital (VHS Eastern CT) and other proposed VHS health systems, specifically, the Waterbury, Saint Mary's and Bristol Health Systems; and (ii) there are any related strategic, marketing, and/or financial analyses related to this transaction and any of those. In response, Applicants only addressed item (i). Please address item (ii).

Response:

There are no strategic, marketing and/or financial analyses related to this transaction and the VHS Waterbury, VHS Saint Mary's and VHS Bristol Health Systems. This transaction is independent of the other three transactions and has been evaluated as such.

16. In response to Question 19 of the Application (page 53), Applicants state that "[n]o service line or service location changes are currently anticipated in connection with the proposed transaction" (the same statement is made on page 59 in response to Question 20). However, in response to question 18 (page 51), Applicants state that this transaction will provide ECHN with the ability to "expand and add needed services, recruit and retain physicians, and improve access to services across its service area." In response to Question 29, page 74, Applicants state that one expected component of the planned capital expenditures "is to add ambulatory access points in the region." Please clarify whether there are plans to add service locations for either MMH or RGH and where Applicants' believe access can be improved.

Response:

In response to Questions 19 and 20, the Applicants did state that no service line or service location changes are currently anticipated in connection with the proposed

transaction, and this statement is accurate. While the Applicants do expect VHS Eastern CT to expand and enhance services as stated in the responses to Question 18 and 29, there are no definitive plans at this time to add service locations for either MMH or RGH. VHS Eastern CT will conduct a planning effort with the Local Board post-closing to determine where there are opportunities to improve access, enhance services and introduce programs that address identified health needs.

17. In reference to the statement "Tenet will use cash to pay the Purchase Price. Cash also will be used for the $75 million in capital expenditures" on page 80 of the Application, please address the following:

    a. Will the full $180 million be paid from Tenet's cash from operations?

    Response:

    The cash purchase price will be paid using Tenet's available cash. Capital expenditures will be paid using VHS Eastern CT's cash from operations. To the extent that VHS Eastern CT's cash from operations cannot fund the $75 million capital commitment, Tenet will provide VHS Eastern CT with an intercompany line of credit to meet these commitments.

    b. Is YNHHS contributing cash to pay for the purchase price and/or capital expenditures?

    Response:

    YNHHS is not contributing cash for the purchase price or capital expenditures.

    c. If applicable, describe the process in which cash from Tenet's accounts will be transferred to VHS Eastern CT to meet the capital expenditure payments.

    Response:

    To the extent that VHS Eastern CT's cash from operations cannot fund the $75 million capital commitment, Tenet will provide the VHS Eastern CT with an intercompany line of credit to meet these commitments.

    d. Will there be an intercompany line of credit set up to fund the $75 million capital expenditures and how else will VHS Eastern CT be assured that these monies will be made available?

    Response:

    Yes, per response to 17(c) above. VHS of Eastern CT is assured the monies will be available as a result of the contractual commitments in the APA.

18. Please provide a supplement to Exhibit 33 (Staffing Attachment I, page 1839 of the Application) showing, for FY 2014, staff to patient ratios calculated using actual average daily census and the number of nursing staff (or RN) full-time equivalents who actually worked in each unit or department instead of budgeted amounts for these categories.

Response:

The staff to patient ratios provided in Staffing Attachment I were calculated utilizing the expected (budgeted) average daily census and nursing full-time equivalents (FTEs) that would be assigned to the unit for a given census. The daily census determines the staff complement that will be assigned to the unit, based on established staffing guidelines.

For example, on a general medical/surgical unit, one nurse can be responsible for up to six patients on the day shift. That nurse to patient ratio guideline is constant regardless of whether there are six patients on the unit or twenty-six patients. If there are only six patients on the unit, then only one nurse is required (with a second non-licensed staff person available to help care for patients). If there are 26 patients on the unit then five nurses are required on the unit to meet the one nurse for every six patient guideline.

The staffing levels for a given day can be increased or decreased as necessary to accommodate the fluctuating patient volume on the unit, so long as they meet the established staffing guidelines. It is the actual daily census and its relationship to the staffing guidelines which determine the level of staffing needed on each unit. Staffing levels do not necessarily change incrementally with an incremental increase in census and will vary by service.

Unit managers are continuously monitoring census and adjusting staffing to the appropriate levels based on the unit's staffing guidelines. Unit managers utilize a worked hours per patient day (WHPPD), also referred to as nursing hours per patient day (NHPPD) statistic to ensure that they are adjusting staffing levels appropriately as changes in census occur. The WHPPD statistic is calculated using actual worked hours and actual patient days. Targets for WHPPD have been established utilizing unit-level benchmarks from National Database of Nursing Quality Indicators (as discussed in the response to Question 48 in the October 24, 2014 CON submission). Managers utilize regular calculations of the WHPPD statistic to ensure that required staffing levels are consistent with the current unit census and will adjust staffing levels periodically throughout the day to achieve the targeted WHPPD.

Following a review of the actual average daily census by unit, it was determined that changes to the calculated nurse to patient ratios (and RN to patient ratios) provided in Exhibit 33 – Staffing Attachment I were necessary for only four of the units. In cases where the actual average daily census differed from the budgeted average daily census, none of the units experienced enough of an increase or decrease in census to result in a change in the staffing levels, as driven by the staffing guidelines, but the resulting ratio

changed slightly due to the change in the daily census (numerator) value. Additionally, the average NHPPD statistic previously provided was based on year-to-date calculations, not the final year-end statistics. These statistics have also been updated to reflect the actual year-end WHPPD.

Staffing Attachment I has been updated to include the revised ratio calculations and the NHPPD statistic as well as the NHPPD target by unit. Please see Exhibit IX for the revised attachment.

Additionally, a supplemental attachment has been provided in Exhibit X. The supplemental attachment provides a summary of actual and budgeted statistics that are utilized to determine appropriate staffing levels and manage WHPPD by unit. Specific statistics include patient days (or visits in the case of the Emergency Department), average daily census, nursing staff FTEs and WHPPD, and RN FTEs and WHPPD.

19. For MMH and RGH, please a provide separate Financial Attachment 1(A) showing one year of actual results and three years of projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

    Response:

    Note that when combined the Financial Attachment for MMH and the Financial Attachment for RGH will not equal the Financial Attachment for ECHN. The variance is attributed to ECHN's other affiliated entities that are presented in the consolidated audited financial statements.

    a. Financial Attachment I(A) - for MMH without the CON project (columns 1,25,8 & 11) and for MMH with the CON project and incremental to the CON project (remainder columns);

       Response:

       Financial Attachment I (A) – for MMH without the CON project, with the CON project, and incremental to the CON project has been included in Exhibit XI.

    b. Financial Attachment I (A) - for RGH without the CON project (columns 1,25, 8 & 11) and for RGH with the CON project and incremental to the CON project (remainder columns);

       Response:

       Financial Attachment I (A) – for RGH without the CON project, with the CON project, and incremental to the CON project has been included in Exhibit XII.

c. Provide the Assumptions used and explain any projected losses from operations; and

Response:

Assumptions used for Financial Attachment I (A) for RGH and MMH are provided in Exhibit XIII. There are not any projected losses from operations resulting from approving this Application.

d. Please submit the Financial Attachments I (A) using the same page and print layouts (size, font, page orientation, margins, etc.) as provided by OHCA.

Response:

Financial Attachments I (A) have been provided using the same page and print layouts as provided by OHCA.

In preparing responses to this question, the Applicants realized Financial Attachment 1(A) in included a mistake that all interest expense was eliminated in the "with CON" scenarios. All interest expense will not be eliminated as the "with CON" scenario will contain interest expense related to capital leases. The Financial Attachment and associated assumptions have been updated and attached as Exhibit XIV.

20. In reference to Assumptions Utilized in Developing Financial Attachment 1, Exhibit 32, please answer the following:

a. Explain the rationale for assuming a modest outpatient growth of 1% with the CON and no projected increase in discharge volume with the CON when on page 89 of the Application it is indicated that Applicants' intention is to make significant capital investments that will drive additional volumes;

Response:

The outpatient growth assumptions included for purposes of the CON are conservative. The Applicants expect that the projected results for outpatient growth will be attained if not exceeded.

b. Explain why the Applicants assumed a 0.5% increase in employee productivity without the CON as well as with the CON and why employee productivity is not expected to increase at a higher percentage rate with the CON than without it;

Response:

The employee productivity assumption included for purposes of the CON is conservative. The Applicants expect that the projected results for employee productivity will be attained if not exceeded as VHS Eastern CT will benefit from the productivity enhancement tools made available by Tenet and YNHHS. Details about these tools are provided in response to Question 29 Part (b) of the Application.

c. Applicants assumed a supply expense reduction of $2.6 million related to the increase in purchasing power from affiliating with Tenet. In reference to this assumption, please address the following:

i. Explain how the total savings of $2.6 million in supply expenses is achieved when, at the same time, Applicants assumed an increase of 3% in supplies and drugs pricing each year with the CON;

Response:

In the "with CON" scenario, the $2.6 million in supply and drug expense savings and the 3% increase in supplies and drugs pricing are two distinct assumptions. The supplies and drugs expense base is reduced by $2.6 million. Supplies and drugs expense increases thereafter are a function of volume and pricing. Pricing is projected to increase by 3% year over year as a result of inflation.

ii. Explain how the total savings in supply chain expenses of $2.6 million with the CON is less than the assumed reduction of $3.7 million in supply chain and purchasing efficiencies without the CON;

Response:

The total savings in supply chain expenses of $2.6 million with the CON is incremental to the $3.7 million in supply chain and purchasing efficiencies without the CON.

iii. Does the $2.6 million include savings for drug supplies as well as for medical supplies? If yes, provide the breakdown. If not, provide the amount in savings for drug supplies related to the projected involvement with Tenet's national vendors; and

Response:

The $2.6 million includes savings for drug supplies as well as for medical supplies. Savings associated with drugs are $400,000 and $2.2 million is associated with medical supplies.

iv. Elaborate on how the $2.6 million in supply expense savings (drugs and medical) will translate into cost savings for MMH's and RGH's patients.

Response:

The $2.6 million in supplies expense savings will allow VHS Eastern CT to continue to be a low cost, high quality healthcare provider for the payors that contract with VHS Eastern CT. As such, MMH's and RGH's patients will benefit from cost savings for their insurance plans as their healthcare insurers will be contracting with a low cost, high quality provider.

d. The Financial Assumptions project cuts of $2.6 million in Medicaid payments and $4.6 million in Medicare due to the wage index factor adjustment. The Applicants also project a reduction in other operating revenue due to cuts in meaningful use incentives. What post-closing plans for MMH and RGH under current ECHN ownership have been made to account for the changes in state and federal hospital funding with and without the CON?

Response:

ECHN has made significant adjustments/reductions for fiscal year 2015 to mitigate the cuts in government payments. Wages have been frozen, jobs have been eliminated and benefits reduced. Even with these measures, the fiscal year 2015 budget calls for an operating loss of $2,900,000. If not for this acquisition, ECHN will be forced to consider more job cuts followed by potential service reductions to ensure continued quality care for the services that remain while maintaining compliance with the organization's bond covenants.

If the transaction is approved, ECHN will be able to make much needed capital investments in infrastructure, technology and programs that will attract healthcare providers and patients who deserve local access to affordable, quality healthcare services. Revenues will improve and, along with reductions in expenses resulting from the economic scale that Tenet brings, ECHN can adapt to the changes in state and federal payments. Please see the response to question 4(f) which discusses the outcomes that will result from the clinical and capital resources that VHS Eastern CT will contribute to the health network.

e. Explain the reduction in Medicare reimbursement due to a one-time adjustment in FY 2014 and provide the dollar amount.

Response:

The amount of the adjustment is $950,000. This adjustment in FY 2014 is due to the fact that the MMH FY 2014 financial statement reflects two years' worth of Medical Education revenue.

The Manchester Memorial Hospital Graduate Medical Education (GME) program officially began on July 1, 2013 (the last quarter of FY 2013). MMH incurred expenses in FY 2013 for the program start up and implementation, without payment from CMS. On the Medicare Cost Report filed February 28, 2014, MMH was due revenue for the FY 2013 Graduate Medical Education program. The $950,000 adjustment represents the FY 2013 Medicare payment for the GME program. Following acceptance of the cost report by CMS, MMH began receiving payments in FY 2014 for FY 2014 expenses related to the GME program in addition to the $950,000 payment received for the FY 2013 expenses. The payment for FY 2013 GME expenses was excluded from the FY 2014 reimbursement baseline prior to developing the FY 2015 reimbursement projections to more accurately reflect the year-over-year growth in reimbursement that is expected from the GME program.

21. In reference to Financial Attachment I(A), please address the following:

    a. Explain the upward projected trend in total operating expenses between FY 2015 and FY 2017;

    Response:

    The upward trend in total operating expense between FY 2015 and FY 2017 is primarily driven by inflation. Fixed expenses grow as a function of inflation. Variable expenses grow as a function of volume and an inflation factor. The salaries and wages inflation factor is the result of a growth in average hourly wage. The supplies and drugs inflation factor is a function of historical supplies pricing. Total operating expense decreases from FY 2014 to FY 2015 because of the cuts that ECHN has put into place to mitigate the effect of reductions in Medicare and Medicaid payments for services.

    b. Provide a breakdown of the amounts reported under the other operating expenses line item, without the CON, and with the CON, for FYs 2015, 2016 and 2017;

    Response:

ECHN Completeness Questions
Question 21, Part B

	FY 2014 Projected W/out CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON
Other	$16,188	$14,912	4,235	$19,147	$15,210	4,235	$19,446	$15,514	4,235	$19,750
Purchased Services	$12,272	$12,518	($2,324)	$10,194	$12,768	($2,371)	$10,397	$13,023	($2,418)	$10,605
Repairs and Maintenance	$4,873	$4,970	$0	$4,970	$5,070	$0	$5,070	$5,171	$0	$5,171
Utilities	$4,412	$4,501	$0	$4,501	$4,591	$0	$4,591	$4,682	$0	$4,682
Billing and Collection	$3,224	$3,289	$0	$3,289	$3,354	$0	$3,354	$3,421	$0	$3,421
Lab	$2,258	$2,303	$0	$2,303	$2,349	$0	$2,349	$2,396	$0	$2,396
Dietary	$2,207	$2,251	$0	$2,251	$2,296	$0	$2,296	$2,342	$0	$2,342
Marketing	$1,347	$1,374	$0	$1,374	$1,401	$0	$1,401	$1,429	$0	$1,429
Biomedical Services	$1,327	$1,354	$0	$1,354	$1,381	$0	$1,381	$1,408	$0	$1,408
Other Operating Expense	**$48,109**	**$47,472**	**$1,911**	**$49,383**	**$48,421**	**$1,865**	**$50,286**	**$49,390**	**$1,817**	**$51,207**

c. Explain the downward projected trend in operating income between FY 2015 and FY 2017.

Response:

The downward trend in operating income between FY2015 and FY 2016 is primarily due to an expected decline in Medicare reimbursement from a wage index update. Operating income between FY2016 and FY 2017 decreases because operating revenues are outpaced by operating expenses which are expected to continually increase, as described in part a of this question.

22. In reference to Tenet's Form 10-K, pages 743, 744, and 747, please provide the factors associated with the increases and decreases for the following accounts between 2012 and 2013:

a. Net Income from $133 million to ($104) million;

b. Total Assets from $9.0 billion to $16.1 billion;

c. Total Liabilities from $7.8 billion to $15.0 billion;

d. Total Equity from $1.2 billion to $878 million; and

e. Cash and Cash Equivalents from $364 million to $113 million.

Response:

As an SEC reporting company, Tenet cannot comment on its financial performance beyond what is provided in Item 7 of Tenet's Form 10-K (Management's Discussion and Analysis of Financial Condition and Results of Operations) and other information filed with the SEC on Quarterly Reports on Forms 10-Q and Current Reports on Form 8-K.

23. Provide revised tables 6 (Population Mix), 8, 9, 10, and 11 (Schedule H) that will include the numeric years associated with the labels "Current" and "Year 1, 2, and 3". With respect to Schedule H, Part II, Community Building Activities for both MMH and RGH, please describe the specific activities included, the amount of spending allocated to each activity and how the projections demonstrate VHS Eastern CT's commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services.

Response

The following tables have been revised to show the numeric years associated with the labels "Current" and "Year 1, 2 and 3":

Table 6: Patient Population / Payer Mix

Manchester Memorial	Current FY 2014	Year 1 FY 2015	Year 2 FY 2016	Year 3 FY 2017
Medicare (1)	41.29%	41.29%	41.29%	41.29%
Medicaid (2)	16.04%	16.04%	16.04%	16.04%
CHAMPUS or TriCare	0.39%	0.39%	0.39%	0.39%
Total Government Payers	**57.73%**	**57.73%**	**57.73%**	**57.73%**
Commercial Insurers (1)	38.99%	38.99%	38.99%	38.99%
Uninsured	2.70%	2.70%	2.70%	2.70%
Workers Compensation	0.58%	0.58%	0.58%	0.58%
Total Non-Government Payers	**42.27%**	**42.27%**	**42.27%**	**42.27%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Rockville General	Current FY 2014	Year 1 FY 2015	Year 2 FY 2016	Year 3 FY 2017
Medicare (1)	29.55%	29.55%	29.55%	29.55%
Medicaid (2)	16.41%	16.41%	16.41%	16.41%
CHAMPUS or TriCare	0.56%	0.56%	0.56%	0.56%
Total Government Payers	**46.52%**	**46.52%**	**46.52%**	**46.52%**
Commercial Insurers (1)	48.56%	48.56%	48.56%	48.56%
Uninsured	4.06%	4.06%	4.06%	4.06%
Workers Compensation	0.86%	0.86%	0.86%	0.86%
Total Non-Government Payers	**53.48%**	**53.48%**	**53.48%**	**53.48%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

(1) Includes managed care activity
(2) Includes managed care activity and other medical assistance

Table 8. Schedule H, Part I, Section 7 - Financial Assistance				
Manchester Memorial Hospital		**Projected**		
		Year 1 FY 2015	**Year 2 FY 2016**	**Year 3 FY 2017**
a	Financial Assistance at cost	1,197,618	1,209,594	1,221,690
b	Medicaid	9,016,210	9,106,372	9,197,436

c	Cost of other means-tested gov't prog.	-	-	-
d	Total Financial Assistance	10,213,828	10,315,966	10,419,126
	Other Benefits			
e	Community health improvement services and community benefit operations	824,210	832,452	840,777
f	Health professions education	2,103,220	2,124,252	2,145,495
g	Subsidized health services	1,471,320	1,486,033	1,500,894
h	Research	263,774	266,411	269,076
i	Cash and in-kind contributions for community benefit	147,617	149,093	150,584
j	Total Other Benefits	4,810,140	4,858,242	4,906,824
k	Total	15,023,968	15,174,208	15,325,950

Table 9. Schedule H, Part I, Section 7 - Financial Assistance				
Rockville General Hospital		**Projected**		
		Year 1 FY 2015	**Year 2 FY 2016**	**Year 3 FY 2017**
A	Financial Assistance at cost	378,610	382,397	386,221
B	Medicaid	3,610,474	3,646,579	3,683,045
C	Cost of other means-tested gov't prog.	-	-	-
D	Total Financial Assistance	3,989,085	4,028,976	4,069,266
	Other Benefits			
E	Community health improvement services and community benefit operations	1,213,963	1,226,103	1,238,364
F	Health professions education	557,860	563,439	569,073
G	Subsidized health services	-	-	-
H	Research	9,131	9,222	9,314
I	Cash and in-kind contributions for community benefit	18,659	18,846	19,035
J	Total Other Benefits	1,799,614	1,817,610	1,835,786
K	Total	5,788,699	5,846,586	5,905,052

Table 10. Schedule H, Part II, Community Building Activities			
Manchester Memorial Hospital	**Projected**		
	Year 1	**Year 2**	**Year 3**

		FY 2015	**FY 2016**	**FY 2017**
1	Physical improvements and housing	-	-	-
2	Economic development	974	984	994
3	Community support	1,432,164	1,446,485	1,460,950
4	Environmental improvements	-	-	-
5	Leadership development and training for community members	-	-	-
6	Coalition building	17,113	17,285	17,457
7	Community health improvement advocacy	5,038	5,088	5,139
8	Workforce development	347,830	351,308	354,821
9	Other	-	-	-
10	Total	1,803,119	1,821,150	1,839,362

Table 11. Schedule H, Part II, Community Building Activities				
Rockville General Hospital		**Projected**		
		Year 1 FY 2015	**Year 2 FY 2016**	**Year 3 FY 2017**
1	Physical improvements and housing	-	-	-
2	Economic development	-	-	-
3	Community support	942	952	961
4	Environmental improvements	-	-	-
5	Leadership development and training for community members	-	-	-
6	Coalition building	115	117	118
7	Community health improvement advocacy	1,755	1,773	1,790
8	Workforce development	175	177	179
9	Other	-	-	-
10	Total	2,988	3,018	3,048

With respect to Schedule H, Part II, the specific activities and the amount of spending allocated to each activity for both MMH and RGH, as reported on the 2012 Form 990 (for FY 2013 which began on October 1, 2012) has been included as Exhibit XV.

ECHN's community benefit activities are established and coordinated at a system level, but must be reported separately for each hospital on Schedule H. Salary expense and

other expenditures associated with the identified Community Building Activities are allocated to either MMH or RGH based on the internal cost center where the expense was incurred. For example, the Family Development Center and behavioral health services are MMH cost centers, so all of the community benefit activity associated with these two areas can only be allocated to MMH. Spending tied to an ECHN cost center, such as those associated with senior leadership or corporate departments (i.e. Marketing and Communications) are allocated to both hospitals, with 70% of the spending credited to MMH and the remaining 30% allocated to RGH.

In general, the types of activities that are provided include community group and community board participation, health fair attendance, and community speaking engagements to provide education and awareness related to healthcare careers, services and economics. Activities such as community group or board participation may be ongoing and recurring engagements. Other activities, such as health fair attendance and the speaking engagements are generally in response to specific requests for ECHN representation or the organization's voluntary decision to participate for the good of the community.

MMH's Family Development Center operates a number of programs for families needing support with parenting and numerous other family issues. Though the programs have various eligibility/enrollment criteria, all serve families who can benefit from parenting support, and all include home visits. Specific programs include:

- **Early Head Start**
- **Family Enrichment Services**
- **Nurturing Families Network programs**
- **School-based Family Resource Centers in Manchester and Vernon**

The projected spending for the Community Building Activities assumes that the same types of activities and services that were provided in FY 2013 will continue to be offered by VHS Eastern CT through FY 2017 and beyond if the proposed Asset Purchase is approved. VHS Eastern CT is committed to providing the same, if not greater, financial support and community benefit to the local community as has historically been provided by MMH and RGH.

24. Please provide monthly financial statistics reports for the months of September and October FY 2014, current month and year-to-date, and comparable period for FY 2013, for each of MMH and RGH only, ECHN, and YNHHS. Thereafter, please provide this same data on a monthly basis for each month, until a public hearing in this matter is held. The following financial measurements/indicators should be addressed in the reports:

Monthly Financial Measurement/Indicators

A. Operating Performance

Operating Margin
Non-Operating Margin
Total Margin
Bad Debt as % Gross Revenue
B. Liquidity
Current Ratio
Days Cash on Hand
Days in Net Accounts Receivables
Average Payment Period
C. Leverage and Capital Structure
Long-term Debt to Equity Long-term Debt to Capitalization
Unrestricted Cash to Debt
Times Interest Earned Ratio
Debt Service Coverage Ratio
Equity Financing Ratio
D. Additional Statistics
Income from Operations
Revenue Over/(Under) Expense
EBITDA
Patient Cash Collected
Cash and Cash Equivalents
Net working Capital
Unrestricted Assets
Credit Ratings (S&P, FITCH and Moody's)

Response:

Monthly financial statistics reports for the month of September, year-to-date, and comparable period for FY 2013, for MMH and RGH only, ECHN, and YNHHS have been included in Exhibit XVI. October 2014 statistics are not yet finalized and will be sent with the requested financial statistics monthly as they become available.

Eastern Connecticut Health Network, Inc.- Proposed Asset Purchase by Tenet Healthcare Corporation and Yale-New Haven Health Services
DN: 14-31926-486 & 14-486-01

Conversion CON Responses to Deficiencies Received Listing of Exhibits

Question #	Exhibit #	Exhibit Title
1	I	Draft Certificate of Incorporation and Draft Bylaws for the Proposed Conversion Foundation
2	II	A Listing of Net Assets of the ECHN Community Healthcare Foundation, Inc. as of 9/30/14, that identifies assets not duplicated on Exhibits 17, 18, and 19 of the Application
3	III	Financial Analysis (Balance Sheet) of Proposed Transaction
10.a	IV	Listing of Health Profession Teaching Programs Supported by ECHN
11.b	V	Tenet’s Charity Care policy
11.d	VI	ECHN’s Policies and Procedures for Financial Assistance/Charity care
12	VII	ECHN 5 Year Proforma – Impact of HIE
13.b	VIII	YNHHS Hospital Compare Reports
18	IX	Revised Staffing Attachment I
18	X	Supplemental Staffing Attachment
19.a	XI	Financial Attachment I (A) for MMH
19.b	XII	Financial Attachment I (A) for RGH
19.c	XIII	Financial Attachment I (A) for MMH & RGH Assumptions
19	XIV	Revised Financial Attachment I (A) for ECHN
23	XV	Schedule H, Part II, Community Building Activities – Activity Detail and Spending Allocated to Each Activity
24	XVI	Monthly Financial Statistics reports for the months of September and October FY 2014, current month and year-to-date, and comparable period for FY 2013, for each of MMH and RGH only, ECHN, and YNHHS

Exhibit I Draft Certificate of Incorporation and Draft Bylaws for the Proposed Conversion Foundation

Exhibit I

CERTIFICATE OF INCORPORATION

[NAME TO BE DETERMINED]

1. The name of the Corporation is ___________________________, Inc. (the "Corporation")].

2. The Corporation shall be organized and operated exclusively for charitable and educational purposes within the meaning of section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended from time to time, or of any corresponding provision of any future United States Internal Revenue Law ("the Code") that benefit, further, support, and carry out the purposes, missions, and objectives of **[name the supported municipalities and public charities]** (the "Supported Organizations") to the extent such purposes, missions, and objectives exclusively support or promote the following purposes:

(a) To maintain and improve the health of the residents of the area historically served by Eastern Connecticut Health Network, Inc., Manchester Memorial Hospital, Inc., and Rockville General Hospital, Inc., specifically, the nineteen communities of Manchester, Vernon (including Rockville), Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Mansfield, Somers, South Windsor, Stafford, Tolland, Union, and Willington (the "Communities");

(b) To support or conduct community health needs assessments and encourage and support efforts to improve the health of the Communities, including the poor, the elderly, the disabled, children, and other underserved and at-risk populations;

(c) To support and engage in community projects, activities, and programs that will improve access to care and enhance the health of residents, including, but not limited to, preventative health programs and health education;

(d) To solicit and accept additional funds to support the Corporation's purposes, and to make grants and provide financial and other support to other non-profit organizations engaged in activities that further the Corporation's purposes;

(f) To support and promote the education and training of medical professionals and providers in the area;

(g) To work cooperatively with VHS Eastern Connecticut Health System, LLC ("VHS Eastern CT, LLC") to ensure and augment a network of affordable and accessible health and medical care in the region; provided, however, that the Corporation will not support programs operated by or for the direct benefit of VHS Eastern Connecticut, LLC, while it operates as a for profit entity; and

(h) To engage in any lawful act or activity for which a corporation may be organized under the Revised Nonstock Corporation Act of the State of Connecticut in furtherance of the foregoing.

The Corporation shall not replace or support any activities or programs that are now or in the future are properly the obligation or responsibility of the government, whether municipal, state, or federal.

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

4. The Corporation shall have no members.

5. The Corporation shall operate under the management of its Board of Directors, all of whom shall reside or work in the Communities. As further provided in the Bylaws, at least a majority of the Board of Directors shall be comprised of individuals appointed to the Board of Directors by the Supported Organizations.

The following individuals are not eligible to serve on the Board of Directors of the Corporation:

(a) A member of the governing board of Eastern Connecticut Health Network, Inc. ("ECHN"), Manchester Memorial Hospital, Inc., Rockville General Hospital, Inc. or any corporate

affiliate of ECHN ("ECHN and its Affiliates") for two (2) years after the later of (1) the date of sale of the assets of ECHN and its Affiliates to VHS Eastern CT, LLC and (2) the date on which their service on the governing board in question ends;

(b) An employee of ECHN or an ECHN Affiliate for two (2) years after such employment has ended;

(c) A member of the local (or advisory) board established pursuant to the Asset Purchase Agreement for the hospitals owned and operated by VHS Eastern CT, LLC for two(2) years after the member's service on the local (or advisory) board ends; and

(d) A member of the governing board or an employee of VHS Eastern CT, LLC, Tenet Healthcare Corporation, Yale-New Haven Health Services Corporation, or one of their affiliates for two years after their service on the board in question or employment ends, as the case may be.

6. No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's Directors, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Paragraph 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from federal income taxation under section 501(c)(3) of the Code or by a corporation contributions to which are deductible under section 170(c)(2) of the Code.

7. If in any taxable year the Corporation is a private foundation as defined by section 509 of the Code, the Corporation will distribute its income for each such tax year at a time and in a manner as not to become subject to

the tax on undistributed income imposed by section 4942 of the Code. Further, in any such year the Corporation will not (1) engage in any act of self-dealing as defined in section 4941(d) of the Code, (2) retain any excess business holdings as defined in section 4943(c) of the Code, (3) make any investments in a manner as to subject it to tax under section 4944 of the Code, or (4) make any taxable expenditures as defined in section 4945(d) of the Code.

8. Upon any dissolution or termination of the existence of the Corporation, **[and following notice to the Attorney General of the State of Connecticut,]** all its property and assets shall, subject to any donor restrictions and after payment of the lawful debts of the Corporation and the expenses of its dissolution or termination, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to one or more organizations selected by the Board of Directors, each of which at the time of such grant qualifies as an exempt organization under section 501(c)(3) of the Code and each of which maintains purposes and engages in activities deemed by the Board of Directors to be consistent with the purposes of the Corporation, in such proportions and for such exclusively charitable or educational purposes as the Board of Directors may determine.

9. In addition to and not in derogation of any other rights conferred by law, a Director of the Corporation shall not be personally liable for monetary damages for breach of duty as a Director in an amount greater than the compensation received by the Director for serving the Corporation during the year of the violation if the breach did not (1) involve any knowing and culpable violation of law by the Director, (2) enable the Director or an associate, as defined by section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain, (3) show a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (4) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

10. The Corporation shall indemnify a Director for liability, as defined in subdivision (5) of section 33-1116 of the Connecticut General Statutes, to any person for any action taken, or any failure to take any action, as a Director, except liability that (1) involved a knowing and culpable violation of law by the Director; (2) enabled the Director or an associate, as defined in section 33-840 of the Connecticut General Statues, to receive an improper personal gain; (3) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

11. The Corporation's initial registered office is ________________________ Connecticut _______. The Corporation's initial registered agent at that office is __________________, with a business address of _________________________, Connecticut ______, and a residence address of ___________________, Connecticut _____.

Acceptance of Appointment

____

12. The incorporator of the Corporation is ______________________________, with a business address of ____________________________________, Connecticut ______, and a residence address of _____________________________________, Connecticut _______.

13. [Describe the method of appointing the initial directors of the Corporation or name the initial Directors.]

14. A Supported Organization that ceases to be exempt under section 501(c)(3) of the Code or that becomes a private foundation under section 509(a) of the Code shall immediately cease to be a "Supported Organization" of the Corporation and shall have no rights or powers with respect to the Corporation; a Director appointed by any such Supported Organization shall immediately be disqualified and removed from the Board of Directors.

15. This Certificate of Incorporation may be amended at any meeting of the Board of Directors by a two-thirds vote of the Directors present and voting, a quorum being present, provided that notice of the proposed amendment shall have been given to each Director at least ten (10) days in advance of the meeting **[, and further provided, that any amendment of Paragraphs 2, 5, 8, and 15 requires the consent of the Attorney General of the State of Connecticut]**.

Dated at _________________, Connecticut, this______ day of ________________, 2014.

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

____

Incorporator

765/2611/3170819.1

Exhibit I

CORPORATE BYLAWS

[NAME TO BE DETERMINED]

ARTICLE I

NAME AND OFFICES

Section 1.1. Name

The name of the Corporation is ____________________________, Inc. (the "Corporation").

Section 1.2. Offices

The principal office of the Corporation will be located at such place in the State of Connecticut as the Corporation's Board of Directors ("Board of Directors" or "Board") may from time to time determine. The Corporation may also have such other offices at such other places both within and without the State of Connecticut as the Board may from time to time determine.

ARTICLE II

PURPOSES

The purposes of the Corporation are those set forth in the Corporation's Certificate of Incorporation on file with the Office of the Secretary of the State of the State of Connecticut, including the following The Corporation shall be organized and operated exclusively for charitable and educational purposes within the meaning of section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended from time to time, or of any corresponding provision of any future United States Internal Revenue Law ("the Code") that benefit, further, support, and carry out the purposes, missions, and objectives of **[name the supported municipalities and public charities]** (the "Supported Organizations") to the extent such purposes, missions, and objectives exclusively support or promote the following purposes:

To maintain and improve the health of the residents of the area historically served by Eastern Connecticut Health Network, Inc., Manchester Memorial Hospital, Inc., and Rockville General Hospital, Inc., specifically, the nineteen communities of Manchester, Vernon (including Rockville), Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Mansfield, Somers, South Windsor, Stafford, Tolland, Union, and Willington (the "Communities") and to support, promote, and engage in activities and programs that will improve the health of the Communities, including the poor, the elderly, the disabled, children, and other underserved and high-risk populations, and access to care, as more fully described in the Certificate of Incorporation.

ARTICLE III

BOARD OF DIRECTORS

Section 3.1. Powers and Duties

The activities, property, affairs and business of the Corporation shall be managed by the Board of Directors. The Board of Directors shall have the power to amend the Corporation's Certificate of Incorporation **[subject to the requirement in the Certificate of Incorporation that the Attorney General of the State of Connecticut must consent to certain amendments]**. The Board of Directors shall also have the power to amend the Corporation's Bylaws and the right to vote on each matter requiring the vote of Directors in the case of corporations without members entitled to vote in accordance with the Revised Nonstock Corporation Act of the State of Connecticut.

Section 3.2. Number and Composition

The Board of Directors shall consist of at least **[eight (8) and not more than fifteen (15)- range to be set when the number of Supporting Organizations is determined]** Directors. The number of Directors serving at any time shall be the number of Directors of the Corporation.

Each Director must reside or work in the Communities, be active and diligent in meeting the obligations of a Director, and be committed to promoting and supporting the welfare, success, and purposes of the Corporation. The Board as a whole should possess the experience, knowledge and perspectives required for the Board to be competent and effective, including but not limited to knowledge about the Communities, the provision of health care services, finance and investment, and grant-making. At least a majority of the Directors on the Board at all times shall be (1) directors appointed by the Supported Organizations pursuant to Section 3.4 of these Bylaws and (2) independent of the Corporation as defined in Article X of these Bylaws.

Section 3.3 Eligibility

Only individuals who reside or work in the Communities are eligible to serve on the Board of Directors.

The following individuals are not eligible to serve on the Board of Directors of the Corporation:

(a) A member of the governing board of Eastern Connecticut Health Network, Inc. ("ECHN"), Manchester Memorial Hospital, Inc., Rockville General Hospital, Inc. or any corporate affiliate of ECHN ("ECHN and its Affiliates") for two (2) years after the later of (1) the date of sale of the assets of ECHN and its Affiliates to VHS Eastern Connecticut Health System, LLC (VHS Eastern Ct, LLC") and (2) the date on which their service on the governing board in question ends;

(b) An employee of ECHN or an ECHN Affiliate for two (2) years after such employment has ended;

(c) A member of the local (or advisory) board established pursuant to the Asset Purchase Agreement for the hospitals owned and operated by VHS Eastern CT, LLC for two (2) years after the member's service on the local (or advisory) board ends; and

(d) A member of the governing board or an employee of VHS Eastern CT, LLC, Tenet Healthcare Corporation, Yale-New Haven Health Services Corporation, or one of their affiliates for two years after their service on the board in question or employment ends, as the case may be.

Section 3.4. Appointment, Election, and Term

The Board of Directors shall consist of Appointed Directors and Elected Directors. The Appointed Directors shall constitute a majority of the Board of Directors

Section 3.4.1 Directors Appointed by Supported Organizations

Each Supported Organization shall appoint one (1) director, each to serve a three (3) year term. **[Add detailed procedures for appointment; these shall take into account the method of appointment of the initial directors and the creation of staggered terms.]** An Appointed Director does not represent or advocate for the specific interests of the Supported Organization that appointed such Director but acts in the best interests of the Corporation generally.

Section 3.4.2 . Elected Directors

The Board of Directors may elect one (1) or more Elected Directors, each to serve a three (3) year term, provided that the number of Elected Directors must be less than half of the Directors. Elected Directors shall possess experience, knowledge, or perspectives that will augment the strength and competence of the Board as a whole. **{Add procedures for election and the maintenance of staggered terms.]**

Section 3.5. Resignation

Any Director may resign at any time by giving written notice to the President or Secretary of the Board of Directors. If the Director is an Appointed Director, the President shall promptly give written notice to the Supported Organization that appointed the Director in question. If no effective date is stated, the resignation shall be effective upon receipt. Acceptance of the resignation shall not be necessary to make it effective.

A Director who ceases to reside or work in the Communities shall automatically be deemed to have resigned from the Board of Directors. A Director who becomes (1) a member of the local (or advisory) board of the two hospitals owned by VHS Eastern CT, LLC or (2) a member of the governing board or an employee of VHS Eastern CT, LLC, Tenet Healthcare Corporation, Yale-New Haven Services Corporation, or one of their affiliates shall

automatically be deemed to have resigned from the Board of Directors.

Section 3.6. Removal

Any Director may be removed **[with or without cause]** by the Board of Directors upon the affirmative vote of a majority of the Directors present and voting at a meeting, a quorum being present, provided that each Director shall have been given written notice prior to the meeting that a purpose of the meeting is to consider the removal of the Director in question. The effective date of removal shall be the date of the meeting at which the vote of the Board of Directors regarding the Director in question occurred, unless otherwise provided by the Board of Directors. A Director removed in accordance with this section shall be notified in writing of said removal. In addition, if the Director is an Appointed Director, the President shall promptly give written notice to the Supported Organization that appointed the Director in question.

Section 3.7. Vacancies

A vacancy shall be deemed to exist if the number of Directors in office is less than the maximum number permitted by these Bylaws. The existence of a vacancy shall decrease the number of Directors in office for the purpose of determining a quorum. A vacancy for an Elected Director may be filled by the Directors at any meeting in accordance with these Bylaws.

Section 3.8. Compensation

The Directors shall serve without compensation for their services as Directors but may be reimbursed by the Corporation for their reasonable expenses and disbursements in that capacity on behalf of the Corporation.

Section 3.9. Regular Meetings of the Board of Directors

The Board of Directors shall have regular meetings at least **[four]** times each year at such times and places as the Board may determine. Reasonable notice of the date, time, and place of each such meeting shall be given to each Director by mail, telephone, telefax, other electronic means, or personally a minimum of two (2) days prior to the meeting, provided that no notice need be given of any meeting held in accordance with a schedule of regular meetings distributed to Directors.

Section 3.10. Special Meetings of the Board of Directors

Special meetings of the Board of Directors may be called by the President and shall be called by the Secretary upon receipt of the written request of a majority of the Directors stating the purpose of such meeting. Reasonable notice of the date, time, place, and purpose of each such meeting shall be given to each Director by mail, telephone, telefax, other electronic means, or personally a minimum of two (2) days prior to the meeting.

Section 3.11. Annual Meeting of the Board of Directors

Unless otherwise fixed by the Board of Directors, the annual meeting of the Board of Directors will be the first regular meeting following the close of the Corporation's fiscal year.

Section 3.12. Waiver of Notice

No notice of a Directors' meeting need be given to any Director (1) who attends such meeting in person, unless the Director at the beginning of the meeting, or promptly upon arrival, objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting or (2) who waives such notice in writing executed and filed with the Secretary of the Corporation, either before or after such meeting. All waivers shall be made part of the minutes of the meeting.

Section 3.13. Action in Lieu of Meeting of the Board of Directors

Any action required or permitted to be taken by the Board may be taken without a meeting if all the Directors consent to such action in writing. Such written consent shall be made a part of the minutes of the proceeding or filed with the corporate records. Such action by written consent shall have the same force and effect as a vote of Directors at a duly convened meeting. For purposes hereof, a Director may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an electronic mail communication from the Director to the Corporation from an electronic mail address provided by the Director to the Corporation.

Section 3.14. Quorum

A majority of the number of Directors in office immediately before a meeting of the Board begins shall constitute a quorum for the transaction of business at that meeting. If a quorum is not present at any meeting of the Board of Directors, a majority of the Directors present may adjourn the meeting, from time to time, without notice other than announcement at the meeting, until a quorum is present.

Section 3.15. Voting

a. The act of a majority of the Directors present at a meeting at which a quorum is present at the time shall be the act of the Board of Directors unless a greater number is required by the Certificate of Incorporation, these Bylaws, or by law.

b. A Director of the Corporation who is present at a meeting of the Board of Directors at which action on any corporate matter is taken shall be presumed to have assented to the action taken unless (1) the Director's dissent is entered in the minutes of the meeting, or (2) such Director either (a) files a written dissent to such action with the person acting as the Secretary of the meeting before the adjournment of the meeting or (b) forwards such dissent by registered mail to the Secretary of the Corporation immediately after the adjournment of the meeting. The right to dissent shall not apply to a Director who voted in favor of such action.

Section 3.16. Director Participation in Meeting by 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 pursuant to this subsection shall constitute presence in person at such meeting.

Section 3.17. Indemnification

The Corporation shall indemnify a Director for liability, as defined in subdivision (5) of §33-1116 of the Connecticut General Statutes, to any person for any action taken, or any failure to take any action, as a Director, except liability that (1) involved a knowing and culpable violation of law by the Director; (2) enabled the Director or an associate, as defined in §33-840 of the Connecticut General Statues, to receive an

improper personal gain; (3) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

ARTICLE IV

OFFICERS

Section 4.1. Designation of Officers

The officers of the Corporation shall be a President, a Secretary, and a Treasurer, and such other officers as the Board of Directors may from time to time determine.

Section 4.2. Election, Term of Office, and Qualification

The officers of the Corporation will be elected annually by the Board of Directors at the annual meeting of the Board of Directors, and each officer will hold office until the earlier of the officer's successor being chosen and qualified or the officer's death, resignation, or removal. Except as may otherwise be provided in the resolution of the Board of Directors choosing an officer, no officer need be a Director. One person may hold, and perform the duties of, more than one office. All officers will be subject to the supervision and direction of the Board of Directors.

Section 4.3. President

The President will preside at all meetings of the Board of Directors. In the President's absence, a person chosen by the Directors present will preside. The President will have and exercise general charge and supervision of the affairs of the Corporation and will do and perform such other duties as the Board of Directors may assign to the President.

Section 4.4. Secretary

The Secretary will act as Secretary of each meeting of the Board of Directors. In the absence of the Secretary, the presiding officer of the meeting will appoint a Secretary of the meeting. In addition, the Secretary or his or her designee will record and keep the minutes of all meetings of the Board of Directors in books to be kept for that purpose; see that all notices and reports are duly given or filed pursuant to these Bylaws or as required by law; be custodian of the records (other than financial) of the Corporation; and in general, perform all duties incident to the office of Secretary and such other duties as the President or the Board of Directors may from time to time assign to the Secretary.

Section 4.5. <u>Treasurer</u>

The Treasurer or his or her designee will have charge and custody of, and be responsible for, all funds and securities of the Corporation and deposit all such funds in the name of the Corporation in such depositories as will be designated by the Board of Directors; exhibit at all reasonable times the Corporation's books of account and records to any Director of the Corporation, upon application during business hours at the office of the Corporation where those books and records are kept; render a statement of the condition of the finances of the Corporation at the annual meeting of the Board of Directors; in general, perform all the duties incident to the office of Treasurer, and such other duties as the President or the Board of Directors may from time to time assign to the Treasurer; and if required by the Board of Directors, give such security for the faithful performance of the Treasurer's duties as the Board of Directors may require.

Section 4.6. <u>Resignation and Removal</u>

Any Officer may resign at any time by giving written notice to the President or the Secretary of the Corporation. The formal acceptance of such resignation shall not be necessary to make it effective. A resignation is effective when the notice is delivered unless the notice specifies a later effective date.

Any Officer may be removed by majority vote of the Directors present and voting at a meeting, a quorum being present, with or without cause. The removal of an Officer shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of an Officer shall not, in and of itself, create any contract rights.

Section 4.7. Vacancies.

A vacancy in any office may be filled for the unexpired portion of the term by the Board at any time.

ARTICLE V

COMMITTEES OF THE BOARD

[To be determined - consider among others Executive, Finance & Investment, Grants, Governance and Nominations, Audit, and Health Committees]

ARTICLE VI

ADVISORY BOARDS AND COMMITTEES

The Board of Directors may from time to time create such advisory boards or committees for the purposes and with the membership determined by the Board. Any such advisory board or committee will consist of persons who are interested in the purposes of the Corporation. An advisory board and committee and each member thereof will be appointed by, and serve at the pleasure of, the Board of Directors, and any vacancy may be filled and any member may be removed, either with or without cause, by the Board of Directors. An advisory board or committee will advise the Board of Directors as to any matters that are put before it by the Board of Directors concerning the Corporation but will not have or purport to exercise any powers of the Board of Directors.

ARTICLE VII

CONFLICTS OF INTEREST AND CONFIDENTIALITY POLICY

Section 7.1. Conflicts of Interest and Confidentiality Policy

The Board of Directors shall adopt a comprehensive policy on conflicts of interest and confidentiality. Such policy shall apply to Directors, officers, and other persons the Board shall designate and shall require the filing of annual disclosure forms. In any event, each Director shall disclose to the Board any conflict of interest that may arise.

Section 7.2. Conflicting Interest Transactions

The Corporation shall comply with the provisions of §33-1127 to §33-1130, inclusive, of the Connecticut General Statutes and other relevant statutes governing a director's conflicting interest transaction.

ARTICLE VIII

FINANCE AND PROPERTY

Section 8.1. Fiscal Year

The fiscal year of the Corporation shall be ______________ through _________________.

Section 8.2. Approved Signatures

All checks, drafts and other orders for the payment of money shall be signed by any Officer, Officers, agent, or agents as shall be thereunto authorized by the Board of Directors.

Section 8.3. Contracts and Debts

Contracts may be entered into or debts incurred only as directed by resolution of the Board of Directors or by its appointed delegate. When the execution of any contract or other instrument has been authorized by the Board of Directors without specification of the executing officer, the President or the Secretary may execute the same in the name of and on behalf of the Corporation.

Section 8.4. Deposits

Funds of the Corporation may be deposited from time to time to the credit of the Corporation with the depositories that are selected by the Board of Directors.

Section 8.5. Recognition of Donors

The Board of Directors may from time to time create named categories to recognize donors who provide monetary or in-kind support to the Corporation.

ARTICLE IX

GRANTS AND OTHER EXPENDITURES

FOR THE ADVANCEMENT OF CHARITABLE PURPOSES

Section 9.1. Authorizations

Grants, gifts, contributions, or other distributions for the advancement of the charitable and educational purposes of the Corporation will be made only if specifically authorized or ratified by the Board of Directors.

Section 9.2. Discretion Retained by Board of Directors

The Board of Directors will at all times maintain complete control and discretion over the distribution of funds received by the Corporation. The Board of Directors may solicit or receive gifts, grants, bequests, or contributions for a specific project that it has reviewed and approved as in furtherance of the purposes of the Corporation as stated in the Certificate of Incorporation. The Board of Directors may, in its absolute discretion, refuse any conditional or restricted gift, grant, bequest, or contribution and return to the donor any such contribution actually received.

Section 9.3. Procedures for Distributions

The Board of Directors will adopt procedures from time to time for grants, gifts, contributions, or other distributions by the Corporation. The procedures will be consistent with Federal tax law and will further the charitable and educational purposes of the Corporation,

Section 9.4. Evaluation and Site Visits

The Board of Directors or officers of the Corporation may make such evaluation and site visits with respect to grants as it deems appropriate from time to time.

The Board of Directors may from time to time create named categories to recognize donors who provide monetary or in-kind support to the Corporation.

ARTICLE X

DIRECTOR INDEPENDENCE

Section 10.1. Generally

At least a majority of the Directors on the Board of Directors shall be individuals who are independent of the Corporation, and members of any committee with responsibility for the Corporation's independent audit or executive compensation shall also be independent.

Section 10.2. <u>Independent Director</u>

A Director is independent if (a) during the Corporation's current fiscal year and at all times during its immediately preceding fiscal year, (i) the Director was not compensated as an officer or employee of the Corporation, (ii) the Director did not receive from the Corporation in any such year total compensation or other payments exceeding $10,000 as an independent contractor, and (iii) neither the Director nor any family member of the Director was involved in a transaction with the Corporation required to be reported on Schedule L, Transactions with Interested Persons, on the IRS Form 990; and (b) the Director, in the judgment of the other independent Directors of the Corporation, does not have any other interest or relationship, whether financial or non-financial, that would cause the Director to be unable to exercise independent judgment on behalf of the Corporation.

Section 10.3. <u>Annual Disclosure</u>

Each Director shall annually provide the information required to determine whether the Director is independent.

Section 10.4. <u>Conflicts of Interest and Confidentiality Policy</u>

Regardless of whether a Director is independent within the meaning of this Article X, every Director is required to comply with the provisions of the Corporation's policy on conflicts of interest and confidentiality and Connecticut laws governing conflicts of interest that apply to nonprofit and charitable corporations.

ARTICLE XI

<u>AMENDMENTS</u>

These Bylaws may be amended at any meeting of the Board of Directors at which a quorum is present by a majority vote of those Directors present and voting, provided that notice of the general nature of such amendments has been sent to the Directors by mail, telefax, other electronic means, or personally at least

ten (10) days preceding the meeting at which they are to be acted upon.

Adopted:____________________, 2015

765/2611/3170820.2

Exhibit II A Listing of Net Assets of the ECHN Community Healthcare Foundation, Inc. as of 9/30/14, that identifies assets not duplicated on Exhibits 17, 18, and 19 of the Application

ECHN Communit HealthCare Foundation, Inc Exhi it II

NE E CHE E 2 02 n
OF EP E BE 30, 2014

E	**ECHN Communit Healthcare Foundation, Inc**	**eported on Exhi it 17**	**eported on Exhi it 18**	**dd l ssets Held the Foundation**
CURRENT ASSETS:				
Cash and cash equivalents	$ 1,107,266			$ 1,107,266
Due from affiliated entities	8,485			8,485
Prepaid expenses	23,740			23,740
Pledges Receivable	228,692			228,692
Total current assets	1,368,183			1,368,183
ASSETS WHOSE USE IS LIMITED				
Donor restricted investments	2,669,078	1,571,508	86,798	1,010,771
Board designated investments	14,611,914			14,611,914
Total assets whose use is limited — net of current portion	17,280,991	1,571,508	86,798	15,622,685
TOTAL ASSETS	$ 18,649,174	$ 1,571,508	$ 86,798	$ 16,990,867
I BI I IE , EQ I Y N NE E				
CURRENT LIABILITIES:				
Accounts payable and accrued expenses	$ (31,006)			$ (31,006)
Due to affiliated entities	(150,796)			(150,796)
Total current liabilities	(181,803)			(181,803)
OTHER LIABILITIES:				
Charitable Gift Annuity (expected future payments)	(3,197)			(3,197)
Total long-term liabilities	(3,197)			(3,197)
Total liabilities	(185,000)			(185,000)
O NE E	**$ 18,464,174**	**$ 1,571,508**	**$ 86,798**	**$ 16,805,867**
* NET ASSETS:				
Unrestricted	2,865,432			2,865,432
Temporarily restricted	14,031,430	4,196	86,798	13,940,436
Permanently restricted	1,567,312	1,567,312		0
Total net assets	$ 18,464,174	$ 1,571,508	$ 86,798	$ 16,805,867

Exhibit III Financial Analysis (Balance Sheet) of Proposed Transaction

ECHN Completeness Questions
Exhi it 3
Balance heet llocation
($000's)

Reference		*A*	*B*	*C*	*D*	*E=B+C+D*	*F=A-E*
			Excluded Entities				
	2013 udit	**ctual ep 2014 Pre Close**	**ECHN Communit HealthCare Foundation**	**Outside rusts**	**Eliminations**	**otal Excluded Entities**	**Base Balance heet**
E							
Cash	$ 22,439	$ 20,734	$ 1,107	$ -	$ (1,107)	$ -	$ 20,734
Current portion of assets whose use is limited	1,851	1,164	-	-	-	-	1,164
Accounts Receivable	46,524	44,625	-	-	-	-	44,625
Inventory	5,066	5,437	-	-	-	-	5,437
Estimated settlements from 3rd party payers	3,463	3,003	-	-	-	-	3,003
Other Current Assets	5,047	4,923	253	-	(253)	-	4,923
Total Current Assets	84,390	79,886	1,360	-	(1,360)	-	79,886
Marketable Securities	13,010	7,138	-	-	-	-	7,138
Assets Whose Use is Limited							
By Donor and Held in Trust	6,535	6,098	2,669	-	-	2,669	3,429
By Board of Trustees	33,138	37,980	14,612	-	(10,941)	3,671	34,309
For Estimated Self Insurance Liability	2,466	5,006	-	-	-	-	5,006
By Bond Indenture	6,793	6,336	-	-	-	-	6,336
Outside Trusts	7,882	11,809	-	11,809	-	11,809	-
(less) current portion	(1,851)	(1,164)	-	-	-	-	(1,164)
Total Assets Whose Use is Limited	54,963	66,065	17,281	11,809	(10,941)	18,149	47,916
Property, Plant, and Equipment	96,188	94,196	-	-	-	-	94,196
Investment in Joint Ventures	13,732	14,528	-	-	-	-	14,528
Deferred Financing Costs	2,580	2,282	-	-	-	-	2,282
Other Noncurrent Assets	17,604	8,972	-	-	-	-	8,972
Total Other Assets	33,916	25,782	-	-	-	-	25,782
Total Assets	$ 282,467	$ 273,067	$ 18,641	$ 11,809	$ (12,301)	$ 18,149	$ 254,918
I BI I IE N NE E							
Current Portion of Long Term Debt	$ 6,832	$ 6,495	$ -	$ -	$ -	-	$ 6,495
Line of Credit	6,500	5,600	-	-	-	-	5,600
Accounts Payable	29,242	29,342	13	-	(13)	-	29,342
Accrued Payroll Expenses	5,634	5,701	-	-	-	-	5,701
Due to Third Parties	4,512	4,524	-	-	-	-	4,524
Accrued Other Expenses	11,626	7,057	164	-	(164)	-	7,057
Total Current Liabilities	64,346	58,719	177	-	(177)	-	58,719
Long Term Obligations	84,416	82,816	-	-	-	-	82,816
Estimated Self Insurance Liability	9,025	9,309	-	-	-	-	9,309
Unfunded Pension Liability	38,111	44,676	-	-	-	-	44,676
Other Long Term Liabilities	720	416	-	-	-	-	416
Total Long Term Liabilities	132,272	137,217	-	-	-	-	137,217
Unrestricted	70,966	58,982	2,866	-	(2,866)	-	58,982
Temporarily Restricted	2,587	2,096	14,031	-	(11,935)	2,096	-
Permanently Restricted	12,296	16,053	1,567	11,809	2,677	16,053	-
Total Net Assets	85,849	77,131	18,464	11,809	(12,124)	18,149	58,982
Total Liabilities and Fund Balance	$ 282,467	$ 273,067	$ 18,641	$ 11,809	$ (12,301)	$ 18,149	$ 254,918

ECHN Completeness Questions
Exhi it 3
Balance heet llocation
($000's)

Reference	*G*	*H*	*G+H=F*	*H*	*I*	*J=H-I*	*E*	*K=J+E*
	Base Balance heet llocation					**otal etained eller**		
	Included in ransaction	**etained eller**	**Base Balance heet**	**etained eller**	**Net e t**	**etained eller a ter Net e t**	**otal Excluded Entities**	**otal etained eller**
E								
Cash	$ 2,073	$ 18,661	$ 20,734	$ 18,661	$ 18,661	$ -	$ -	$ -
Current portion of assets whose use is limited	-	1,164	1,164	1,164	1,164	-	-	-
Accounts Receivable	44,625	-	44,625	-	-	-	-	-
Inventory	5,437	-	5,437	-	-	-	-	-
Estimated settlements from 3rd party payers	-	3,003	3,003	3,003	-	3,003	-	3,003
Other Current Assets	4,923	-	4,923	-	-	-	-	-
Total Current Assets	57,058	22,828	79,886	22,828	19,825	3,003	-	3,003
								-
Marketable Securities	-	7,138	7,138	7,138	7,138	-	-	-
								-
Assets Whose Use is Limited								
By Donor and Held in Trust	-	3,429	3,429	3,429	3,429	-	2,669	2,669
By Board of Trustees	-	34,309	34,309	34,309	34,309	-	3,671	3,671
For Estimated Self Insurance Liability	5,006	-	5,006	-	-	-	-	-
By Bond Indenture	-	6,336	6,336	6,336	6,336	-	-	-
Outside Trusts	-	-	-	-	-	-	11,809	11,809
(less) current portion	-	(1,164)	(1,164)	(1,164)	(1,164)	-	-	-
Total Assets Whose Use is Limited	5,006	42,910	47,916	42,910	42,910	-	18,149	18,149
Property, Plant, and Equipment	94,196	-	94,196	-	-	-	-	-
Investment in Joint Ventures	14,528	-	14,528	-	-	-	-	-
Deferred Financing Costs	2,282	-	2,282	-	-	-	-	-
Other Noncurrent Assets	8,838	134	8,972	134	-	134	-	134
Total Other Assets	25,648	134	25,782	134	-	134	-	134
Total Assets	$ 181,908	$ 73,010	$ 254,918	$ 73,010	$ 69,873	$ 3,137	$ 18,149	$ 21,286
I BI I IE N NE E								
Current Portion of Long Term Debt	$ -	$ 6,495	$ 6,495	$ 6,495	$ 6,495	$ -	$ -	$ -
Line of Credit	-	5,600	5,600	5,600	5,600	-	-	-
Accounts Payable	29,342	-	29,342	-	-	-	-	-
Accrued Payroll Expenses	5,701	-	5,701	-	-	-	-	-
Due to Third Parties	-	4,524	4,524	4,524	-	4,524	-	4,524
Accrued Other Expenses	7,057	-	7,057	-	-	-	-	-
Total Current Liabilities	42,100	16,619	58,719	16,619	12,095	4,524	-	4,524
			-					
Long Term Obligations	9,960	72,856	82,816	72,856	72,856	-	-	-
Estimated Self Insurance Liability	9,309	-	9,309	-	-	-	-	-
Unfunded Pension Liability	44,676	-	44,676	-	-	-	-	-
Other Long Term Liabilities	416	-	416	-	-	-	-	-
Total Long Term Liabilities	64,361	72,856	137,217	72,856	72,856	-	-	-
Unrestricted	75,447	(16,465)	58,982	(16,465)	(15,078)	(1,387)	-	(1,387)
Temporarily Restricted	-	-	-	-	-	-	2,096	2,096
Permanently Restricted	-	-	-	-	-	-	16,053	16,053
Total Net Assets	75,447	(16,465)	58,982	(16,465)	(15,078)	(1,387)	18,149	16,762
Total Liabilities and Fund Balance	$ 181,908	$ 73,010	$ 254,918	$ 73,010	$ 69,873	$ 3,137	$ 18,149	$ 21,286

ECHN Completeness Questions
Exhi it 3
Net Proceeds nal sis
($000's)

Enterprise alue	**$**	**105,000**
ssumed ia ilities		
Pension & Post Retirement Liability		44,676
Asbestos Abatement		416
Captive & Workers Compensation		10,671
Capital Leases		9,960
Total Assumed Liabilities		65,723
Net Wor ing Capital djustment		
Target Net Working Capital		24,000
Net Working Capital as of 9/30/14		12,885
Net Working Capital Adjustment		11,115
Cash Purchase Price	**$**	**28,162**
Net e t		
Debt		
Current Portion of Long Term Debt		6,495
Line of Credit		5,600
Long Term Obligations		72,856
Total Debt		84,951
Assets Available for Debt Retirement		
Existing Cash		18,661
Marketable Securities		7,138
Assets Whose Use is Limited:		
By Donor and Held in Trust		3,429
By Board of Trustees		34,309
By Bond Indenture		6,336
Total Assets Available for Debt Retirement		69,873
Net e t		15,078
Cash Balance a ter e t etirement	**$**	**13,084**
ssets etained eller		
Cash Balance after Debt Retirement	$	13,084
Estimated settlements from 3rd party payers		3,003
Assets Whose Use is Limited:		
By Donor and Held in Trust		2,669
By Board of Trustees		3,671
Outside Trusts[1]		11,809
Other Noncurrent Assets		134
Total Assets Retained by Seller	$	34,370
ia ilites etained eller		
Due to Third Parties	$	4,524
Total Liabilities Retained by Seller	$	4,524
Net Assets Retained by Seller	$	29,846
Total Liabilities and Net Assets	$	34,370

Notes:
[1]Outside Trusts are subject to Probate review of assignment post-closing

Exhibit IV Listing of Health Profession Teaching Programs Supported by ECHN

ECHN Health Education Affiliations

Behavioral Health Services Education Affiliations
American International College
Cambridge College
Capella University
Manchester Community College (Connecticut, State Board of Regents for Higher Education)
Fordham University
Goodwin College
Springfield College
University of Connecticut

Cardiovascular and Neurology Services Health Education Affiliations
Hoffman Heart Institute School of Cardiovascular Ultrasound - Saint Francis Hospital and Medical Center
Central Connecticut State University
Manchester Community College
University of Connecticut

CorpCare Health Education Affiliations
Quinnipiac University
University of Connecticut

Eastern Connecticut Medical Professionals Health Education Affiliations
Branford Hall Career Institute
Goodwin College
Sawyer Butler Business School

Food and Nutrition Services Health Education Affiliations
University of St. Joseph
University of Connecticut

Laboratory Science Health Education Affiliations
Asnuntuck Community College
Goodwin College

Medical Education Department Health Education Affiliations
Barry University School of Podiatry
California School of Podiatric Medicine at Samuel Merritt College
Des Moines University Osteopathic Medical School

Medical Education Department Health Education Affiliations (continued)
DesMoines University College of Podiatric Medicine
Edward Via College of Osteopathic Medicine
Kansas City University of Medicine and Biosciences of Osteopathic Medicine
Lake Erie College of Osteopathic Medicine
New York College of Podiatric Medicine
Ohio College of Podiatric Medicine
Quinnipiac University
Springfield College
Temple University School of Podiatric Medicine
Touro University Nevada College of Osteopathic Medicine
University of Connecticut School of Medicine
University of New England College of Osteopathic Medicine
West Virginia School of Osteopathic Medicine
Western University of Health Sciences
William M. Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine and Science

Medical Imaging Services Health Education Affiliations
Capital Community College
University of Hartford

Nursing Services Education Health Education Affiliations
Capital Community College
Goodwin College
Manchester Community College
Quinnipiac University
Sacred Heart University
University of St. Joseph
University of Connecticut
University of Hartford
Yale University

Pharmacy Services Health Education Affiliation
University of Connecticut

Rehabilitation Services Health Education Affiliations
American International College
Boston University
Goodwin College
Naugatuck Valley Community College

Rehabilitation Services Health Education Affiliations (continued)
Northeastern University
Quinnipiac University
Sacred Heart University
Springfield College
Springfield Technical Community College
University of Connecticut
University of Hartford
University of Massachusetts-Amherst
University of Montevallo

Visiting Nurse and Health Services of CT Health Education Affiliations
University of Connecticut
University of St. Joseph

Women's Center for Wellness Health Education Affiliations
Brandeis University
Branford Hall Career Institute
Stone Academy

Woodlake at Tolland Health Education Affiliations
Goodwin College
Manchester Community College
University of Connecticut
University of St. Joseph

Exhibit V Tenet's Charity Care policy

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Patient Access......02

Charity/Indigent/MEP......02.06

Charity Care Policy......02.06.01

Charity Care Policy – California......02.06.02A

Charity Discount Care Policy – California......02.06.02B

Charity Care Policy

I. POLICY:

The determination of Charity Care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of the patient to pay. Designation as Charity Care will only be considered after all payment sources have been exhausted. The co-pay amount will be pursued for all charity accounts with the exception of deceased and homeless patients with no other guarantor. Patient account transactions for Charity Care must be posted in the month the determination is made.

The flat rate "co-pay" amount is based on patient type. Emergency patients and outpatients are required to pay $100 flat rate and inpatients are required to pay $200 per day, with a $2,000 cap.

In the event the account has been assigned as Bad Debt to SOS/CFC as part of the monthly SOS journal entry, it will reverse the PA recovery that was given on an account determined to be Charity Care.

Note: EMPLOYEES OF TENET SHOULD NOT, AT ANY TIME, INDICATE OR SUGGEST TO THE PATIENT THAT HE/SHE WILL BE RELIEVED OF THE DEBT BY WAY OF A WRITE-OFF TO CHARITY CARE UNTIL THE DETERMINATION HAS BEEN MADE.

II. SCOPE:

All Tenet Patient Accounting Platforms

III. PURPOSE:

To define Charity Care and to distinguish Charity Care from accounts assigned to Bad Debt. Additionally, to establish policies and procedures to ensure consistent identification, accountability, and recording of charity at all Tenet entities and facilities.

IV. DEFINITIONS:

Charity Care represents all healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately classify the revenue and any Bad Debt expense previously recorded.

Charity Care will be classified into four categories:

A. Charity Care – Statutory

Statutory Charity Care will be defined by facility participation in various Federal, State, and/or County uncompensated care programs. Criteria for such Charity Care must comply with governmental guidelines and/or State or County regulations. Statutory Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility. Each patient who appears eligible for Statutory Charity Care determination and requests such determination must complete a Confidential Medical and Financial Assistance Application (hereafter referred to as the Confidential Financial Application—or, as application—as illustrated in *Exhibit B*). The patient/guarantor must complete all areas of the application and attest to the accuracy of the information by signing the application. The application will be processed in accordance with the Tenet Charity Care Program Policy and Procedures.

Each facility may need to have a number of Statutory Charity Care accounts to provide for the separation and identification of Charity Care by specific program and/or obligation. Statutory Charity Care will generally be identified at the time of admission by the facility, Tenet Financial Assistance Center (TFAC), or while the patient is in-house; however, it may also be identified after discharge.

The following accounts have been added to the Acute Chart of Accounts:

1. 5950-3934 Charity Discount - Statutory I/P
2. 5950-4934 Charity Discount - Statutory E/R
3. 5950-6934 Charity Discount - Statutory O/P

B. Charity Care – Non-Statutory

Non-Statutory Charity Care is defined as patient Charity Care meeting Tenet's Charity Care criteria; however, there may not be State or County programs in which the facility participates or where the facility does not have specific obligations to provide Charity Care. TFAC will determine eligibility for Non-Statutory Charity Care. The determination will be performed after the Confidential Financial Application is submitted for processing. An effort will be made to secure a signed application, but this may not be possible in all cases and will not prevent an account from being qualified by TFAC as Charity Care.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3935 Charity Discount - Non-Statutory I/P
2. 5950-4935 Charity Discount - Non-Statutory E/R
3. 5950-6935 Charity Discount - Non-Statutory O/P

C. Charity Care – Medicaid Denied Stays/Care, Non-Covered Services

Medicaid Charity Care will be defined as a category of patients who qualify for Medicaid, pursuant to governmental guidelines and/or State or County regulations, but where an outstanding patient balance exists, excluding waivers of deductibles and co-payments, unless otherwise documented and compliant with Tenet Regulatory Compliance Policy guidelines. Medicaid Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility.

Each patient who appears to be eligible for Medicaid Charity Care determination will not be required to complete a Confidential Financial Application due to the fact that Medicaid eligibility, in itself, is deemed to meet the requirements of Charity and, therefore, meets Tenet's criteria for Charity Care.

Under the Tenet Medicaid Charity Care Policy definition, these patients are eligible for Charity Care write-offs. Charges not billable or "un-billable" to the patient may not be claimed as Charity Care where it is not allowed by State law/regulation. Billable charges related to denied days, denied days of care, non-covered services, and any denied treatment authorizations will be included as Medicaid Charity Care. In addition, Medicare patients who have Medicaid coverage for their co insurance deductibles for which Medicaid will not make any additional payment, and for which Medicare does not ultimately provide Bad Debt reimbursement, will also be included as Charity Care.

At no time shall a facility claim Charity Care attributed to Medicaid billable charges as either Statutory or Non-Statutory Charity.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3940 Medicaid Denied Days I/P
2. 5950-4940 Medicaid Denied Services E/R
3. 5950-6940 Medicaid Denied Services O/P

D. Charity Care – Catastrophic Medically Indigent

For patients whose family income to the Federal Poverty Guidelines (FPG) ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for the Catastrophic Medically Indigent category. The determination for this is completed after comparing the patient's gross income, income to FPG ratio, and amount of hospital charges as follows:

1. **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

2. **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).

3. **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

4. **Unable to Pay**—It is determined the patient is unable to pay.

The following account descriptions have been revised in the Acute Chart of Accounts:

1. 5950-3941 Catastrophic Medically Indigent Discount - I/P

2. 5950-4941 Catastrophic Medically Indigent Discount - E/R

3. 5950-6941 Catastrophic Medically Indigent Discount - O/P

V. PROCEDURE:

The hospital Financial Counselor or MEP Patient Advocate will attempt to identify potential Statutory and Non-Statutory Charity Care at the time of admission or while the patient is in-house. At the time of Charity identification, the financial class will be changed to Charity Care, the co-pay will be collected based on admission type, and a 100% Charity Care allowance should be taken for these patients. At the time of the financial class change, the patient's account will be assigned to TFAC and the Confidential Financial Application should be forwarded to TFAC for review and processing. Additionally, all CFC-, MEP-, and Early Out-assigned patient accounts—post-discharge—that qualify to be reviewed for Charity Care should be forwarded to TFAC. Completed Charity Care packets will be forwarded to the respective facility. TFAC will also retain the Charity Care packets, including applications for Charity Care, appropriate back-up documentation, and recommendations for possible retrospective audit by the Business Office and/or Tenet Audit Services.

A. Factors to be Considered

Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published FPG, or an equivalent thereof. The patient's gross income information may be obtained from a Confidential Financial Application, but is not required. This information may be obtained through verbal means from the patient/guarantor and documented by a MEP Patient Advocate, Financial Counselor, Financial Assistance Coordinator, or other specifically designated Tenet employee.

Other factors may include, but are not limited to, the following:

1. The patient's employment status, credit status, and capacity for future earnings.

    a) Patients who are unemployed and do not qualify for a government program

    b) Patients who have no credit established and no Bad Debt collection accounts

    c) Patients with a lack of revolving credit account(s) information

    d) Patients with a lack of revolving bank accounts(s) information

    e) Patients with delinquencies reported on open trade line accounts

2. The previous exhaustion of all other available resources.

3. International patients are considered on a case-by-case basis for ER treatment and/or ER admission only.

4. Catastrophic illness.

VI. MEP PROCEDURE:

The MEP Patient Advocate should screen patients for potential linkage to Government/County programs. During the screening process, the Advocate should secure a Confidential Financial Application. The application is to be used for potential Charity Care determination only in the event MEP is unable to obtain eligibility for the patient for Government Programs reimbursement. For potential linkage to Government/County programs, the Patient Advocate will:

A. Change the financial class and assign the account to MEP within five days from date of discharge, thereby, netting the account to expected governmental reimbursement.

B. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.

C. Return the account to the facility for assignment by the Business Office to Early Out for Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those meeting the financial guidelines for Charity Care will be assigned by the Business Office to TFAC with the appropriate financial class. The co-pay should be collected by the hospital's Financial Counselor, Business Office representative, or TFAC representative.

If, during the initial interview with the patient, it is revealed that there is no viable source of payment and the patient will not qualify for any governmental programs, the Patient Advocate will:

A. Offer the patient a Confidential Financial Application form.

B. Assist the patient in completing a Confidential Financial Application, which will document the patient's financial need.

C. Obtain the patient's signature on the Confidential Financial Application and forward the application to the Financial Counselor or TFAC, as deemed appropriate.

D. Refer the patient to the hospital Financial Counselor for collection of the co-pay.

MEP Processing for Charity Care

For those accounts that remain in MEP past 30 days from assignment with no government program linkage and that meet the financial criteria for Charity Care, MEP should have gathered all substantial information to enable the facility to affect Tenet's Charity Care Policy. Included in the Charity Care packet is a Confidential Financial Application. If the MEP representative has exhausted all efforts to secure all necessary verifications, the application for Charity Care should be submitted to TFAC for review and finalization without the verifications.

MEP is required to notify the Business Office of the inability to obtain eligibility, or the potential qualification for Charity Care classification, and to return the account to the Business Office.

The Business Office is required to update the plan ID and financial class for assignment to TFAC.

TFAC will further assess the application.

VII. FINANCIAL COUNSELOR PROCEDURE:

Patients assessed by a Financial Counselor to have no third-party coverage and/or benefits available will:

A. Be offered the facility flat rate or Prompt Pay Discount Program where allowed by State law/regulation.

B. Be assessed for Charity Care in the event he or she is unable to pay the facility flat rate or Prompt Pay Discount Program amount (as applicable to State law/regulation), and meets the income/asset and other guidelines set forth by the Charity Care Policy.

The Financial Counselor will take the appropriate steps as outlined below:

A. For patients who appear to meet the income guidelines set forth in this policy for Charity Care, the account should be updated with the financial class of Charity on the facility system, at which time, a 100% Charity Care reserve should be taken and the co-pay amount should be collected. The patient account is then assigned to TFAC for review follow-up and a final Charity Care recommendation. The Financial Counselor should forward the Confidential Financial Application to TFAC.

B. Patients who do not qualify for Charity Care should be treated as a Self-Pay, and standard A/R collection procedures will apply.

VIII. TENET FINANCIAL ASSISTANCE CENTER:

All accounts assigned to TFAC that are potentially Charity Care will be evaluated within 25 days. During the assessment period, the account's financial class may be changed to Charity Care on the facility's system and a 100% reserve taken.

Those accounts that do not meet the financial guidelines, which were assigned to TFAC for Charity Care assessment, will have the financial class changed to Self-Pay on the facility's system and will be assigned to Early Out.

For patient accounts meeting the Charity Care guidelines:

A. The TFAC Financial Assessment Coordinator will gather all substantial information to enable the facility to affect Tenet's Charity Care Policy.

B. The Charity Care packet should include a Confidential Financial Application, a Credit Bureau Report, and any other documents that substantiate the patient's financial need for Charity consideration. Where the patient is unable to complete a written Confidential Financial Application, verbal attestation is acceptable.

The amount of information to support a Charity Care recommendation will vary depending on TFAC's ability to effectively obtain the information from the patient or family.

When TFAC is unable to obtain hard-copy documentation from the patient or family, but all indications—from the information received verbally or in writing at the time of service (or soon thereafter)—are that the patient would qualify for Charity Care, then TFAC will complete a Confidential Financial Application recommending Charity Care. The application will include:

1. A Credit Bureau Report or summary
2. An analysis that supports the recommendation for a Charity Care adjustment

C. The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

1. Credit Bureau Report (including the lack thereof)
2. IRS tax returns
3. Payroll stubs
4. Declarations
5. Verbal attestation
6. Other forms used to substantiate the need for Charity Care consideration

D. The Financial Assessment Coordinator will apply FPG guidelines by using the FPG table (refer to *Exhibit A*), which is updated annually. The patient's family size is used to determine whether monthly or annual income falls at, below, or exceeds 200% of the FPG. Where State law/regulation does not allow for consideration of Charity up to 200% of the FPG, the State law/regulation will take precedent and be enforced.

1. If the family gross income falls below, or is at the designated income of the FPG ratio threshold, the patient's account will be considered for Charity Care adjustment at 100% minus the co-pay amount

   Note: Tenet Policy's ratio is 200%, which is influenced by State law/regulation.

2. For patients whose family income to the FPG ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for a Catastrophic Medically Indigent discount. The calculation for this is completed after comparing the patient's gross income, income to the FPG ratio, and the amount of hospital charges as follows:

   a) **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

   b) **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).

   c) **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

   d) **Unable to Pay**—It is determined the patient is unable to pay.

   Note: All four of the above criteria must be met for consideration as Catastrophic Medically Indigent.

3. If the co-pay was not collected at the time of service, the Financial Assistance Coordinator will attempt to collect the amount before the Charity Care packet is submitted.

E. The Financial Assistance Coordinator will complete a Confidential Financial Application that indicates there are no other payment sources and the patient meets the income of the FPG guidelines.

F. TFAC is to review the application for Charity Care for appropriateness and completeness. Initialing the application indicates that it has been reviewed and meets the requirements for submission to the facility for Charity Care consideration and administrative adjustment.

G. If the TFAC representative has exhausted all efforts for those patients who meet Government Programs or Charity Care criteria, but are unable to complete the required applications and documentation (e.g., unable to contact the patient, unable to provide sufficient documentation, etc.), and/or have a potential change in future circumstances and recovery, then the account will not be recommended for a Charity Care allowance.

H. Those patients who do not meet the guidelines for Charity Care will have their accounts changed back to Self-Pay, and standard A/R follow-up will begin.

At all times, the Collection, Support, and Management staff of TFAC are required to input complete documentation on the account of all actions taken and all information received from the patient. It is the responsibility of the TFAC Operations management to ensure adherence to this policy.

IX. DOCUMENTATION:

A. Confidential Financial Application

In order to qualify for Charity Care, Tenet requests each patient or family to complete the Confidential Financial Application. This application allows the collection of information about income and the documentation of other requirements as defined below. Pending the completion of the application, the patient should be treated as a Charity Care patient in accordance with Tenet's Charity Care Policy as set forth here. The patient's account will have the financial class changed to Charity Care on the facility's HIS system.

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by State law/regulation.

A Confidential Financial Application completed by the patient may not be required for patients who are deemed to be already eligible for other Federal, State, and County Assistance Programs. Such programs include, but are not limited to Medicaid, County Assistance Programs, MIA, MSI, AFDC, Food Stamps, and WIC.

1. **Family Members**—Tenet will require patients to provide the number of family members in their household.

   a) Adults—To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their dependents.

b) Minors—To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

2. **Income Calculation**—Tenet requires patients to provide their household's yearly gross income.

   a) Adults—The term "yearly income" on the application means the sum of the total yearly gross income of the patient and the patient's spouse.

   b) Minors—If the patient is a minor, the term "yearly income" means the income from the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

3. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income. Although no documentation of income and no Confidential Financial Application are required for expired patients, the patient's financial status will be reviewed at the time of death by TFAC to ensure that a Charity Care adjustment is appropriate. The co-pay will be waived if no other guarantor appears on the patient account.

4. **Homeless Patients**—Patients may be deemed homeless once verification processes have been exhausted by TFAC. The co-pay will be waived if no other guarantor appears on the patient account.

B. Income Verification

Tenet requests patients to attest to the income set forth in the application. In determining a patient's total income, Tenet may consider other financial assets and liabilities of the patient, as well as, the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay their bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for Charity Care:

1. **Income Documentation**—Income documentation may include IRS W-2 form, Wage and Earnings Statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.

2. **Participation in a Public Benefit Program**—Public Benefit Program documentation showing current participation in programs, such as Social Security, Workers' Compensation, Unemployment Insurance, Medicaid, County Assistance Programs, AFDC, Food Stamps, WIC, or other similar indigence-related programs.

3. **Assets**—All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

C. Information Falsification

Information falsification will result in denial of the Charity Care application. If, after a patient is granted financial assistance, the hospital/SOS finds material provision(s) of the application to be untrue, Charity Care status may be revoked and the patient's account will follow the normal collection processes.

D. Revenue Classification

It will be the responsibility of each Business Office to maintain the integrity of account classification on the hospital patient accounting system. Prior to month-end close, TFAC is responsible for providing detailed reports listing critical changes in account class between Self-Pay and Charity for any A/R account assigned to TFAC. The Business Office is required to use those reports to update the changes in the patient accounting system prior to the month-end.

Critical changes in account class are defined as:

1. Any account originally assigned to TFAC as Self-Pay that is re-classed as a result of meeting the criteria for Charity Care

2. Any account originally assigned to TFAC as Charity that is re-classed to Self-Pay as a result of denying Charity Care

E. Denied Charity Care Recommendations

In the event the CFO denies a patient's application for Charity Care, documentation is to be placed in the facility collection system as to the reason for the rejection of the recommendation. The CFO is also to indicate on the Confidential Financial Application the reason for denial and the date of the denial. The packet is then to be forwarded to TFAC for review. After an initial review and discussion with the CFO, for those patient accounts where disagreement still prevails, and the accounts that meet Tenet guidelines for Charity Care as set forth here, a denial summary will be sent to the respective Tenet Regional Vice President of Finance by TFAC for resolution. For those patient accounts that the Regional Vice President of Finance has denied that have met the Tenet Charity Care guidelines as set forth here, a denial summary will be sent to the respective Tenet Divisional Senior Vice President of Finance for conference and resolution.

F. Custodian of Records

TFAC will serve as the custodian of records for all Charity Care documentation for all accounts identified by SOS, MEP, and CPFS.

G. Reservation of Rights

It is the policy of Tenet and the hospital to reserve the right to limit or deny financial assistance at their sole discretion.

1. **Non-Covered Services**—It is the policy of Tenet and the hospital to reserve the right to designate certain services that are not subject to the hospital's Charity Care Policy.

2. **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payers, patient transfers, emergency care, State-specific regulations, State-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

X. EXHIBIT A – FEDERAL POVERTY GUIDELINES:

2004 Federal Poverty Guidelines (FPG) are as follows:

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$9,310	18,620	27,930	$11,630	23,260	34,890	$10,700	21,400	32,100
2	12,490	24,980	37,470	15,610	31,220	46,830	14,360	28,720	43,080
3	15,670	31,340	47,010	19,590	39,180	58,770	18,020	36,040	54,060
4	18,850	37,700	56,550	23,570	47,140	70,710	21,680	43,360	65,040
5	22,030	44,060	66,090	27,550	55,100	82,650	25,340	50,680	76,020
6	25,210	50,420	75,630	31,530	63,060	94,590	29,000	58,000	87,000
7	28,390	56,780	85,170	35,510	71,020	106,530	32,660	65,320	97,980
8	31,570	63,140	94,710	39,490	78,980	118,470	36,320	72,640	108,960
Each additional person, add	3,180	6,360	9,540	3,980	7,960	11,940	3,660	7,320	10,980

XI. EXHIBIT B – CONFIDENTIAL FINANCIAL APPLICATION:

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name	SSN	DOB
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A

MEDICAL ASSISTANCE SCREENING – *Please circle answer "Y" for yes or "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? Y / N *If yes, does the patient have a 30-day incapacitation?*
5. Is the patient pregnant, or was the admission pregnancy-related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household _______________

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_______________ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size

___________________________ ÷ ___________________________ = _______%

Type of Service Circle one ER OP IP

Service Date _______________ to _______________

Co-Pay Amount $_______________________

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$9,310	18,620	27,930	$11,630	23,260	34,890	$10,700	21,400	32,100
2	12,490	24,980	37,470	15,610	31,220	46,830	14,360	28,720	43,080
3	15,670	31,340	47,010	19,590	39,180	58,770	18,020	36,040	54,060
4	18,850	37,700	56,550	23,570	47,140	70,710	21,680	43,360	65,040
5	22,030	44,060	66,090	27,550	55,100	82,650	25,340	50,680	76,020
6	25,210	50,420	75,630	31,530	63,060	94,590	29,000	58,000	87,000
7	28,390	56,780	85,170	35,510	71,020	106,530	32,660	65,320	97,980
8	31,570	63,140	94,710	39,490	78,980	118,470	36,320	72,640	108,960
Each additional person, add	3,180	6,360	9,540	3,980	7,960	11,940	3,660	7,320	10,980

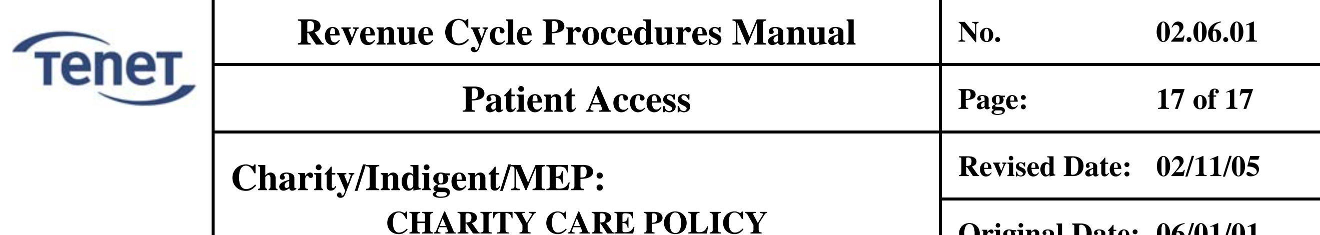
In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	Check One - Living on Savings/Annuity Live with parent/family/friends Homeless Shelter	

SPOUSE

Responsibility Party:		
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	



HOMELESS AFFIDAVIT

I, ____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.
Patient/Guarantor Initials ______

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Tenet Charity Care programs is a "Payer of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet's or its subsidiaries provided care.

____ ____________

PATIENT/GUARANTOR SIGNATURE **DATE**

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
Prepared by		Date	Unit
Approved or Denied by		Date	Title

Charity Care Policy – California

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation, its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of 50% or more; and (3) any hospital or healthcare facility in which Tenet or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tenet Facility") (collectively, "Tenet").

This policy applies to all Tenet California facilities.

II. PURPOSE:

To provide free or discounted healthcare to patients treated at Tenet California facilities that have an inability to pay for their care.

III. POLICY:

Tenet is committed to providing high quality, comprehensive health care services, regardless of a patient's ability to pay. Tenet strives to ensure that the financial situation of people who need health care services does not prevent them from seeking or receiving care. Charity Care is not considered to be a substituent for personal responsibility, and patients are expected to cooperate with Tenet's procedures for obtaining financial assistance and to contribute to the cost of their care based on individual ability to pay.

The determination of Charity Care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of the patient to pay. Designation as Charity Care will only be considered after all payment sources have been exhausted.

The discount amount is based on household income compared to the Federal Poverty Limit (FPL) for the current year. Those with household income under 200% FPL will be eligible for free care for the date of service in which an application is completed.

Uninsured or Under-insured patients (as defined below) with family income between 201% and 350% FPL will be eligible for care at a sliding scale discount. (Refer to RCPM Policy 02.06.02B for additional information.)

Uninsured patients whose family income exceeds 350% of the federal poverty level will receive the Compact discounted rate. (Refer to RCPM Policy 02.02.09 for additional information.)

IV. DEFINITIONS:

A. Charity Care

Charity Care represents all Tenet healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately classify the revenue and any Bad Debt expense previously recorded.

B. Under-insured Patients

An "Under-insured Patient" is an insured patient with "high medical costs". These are insured patients whose family income does not exceed 350% of the FPL and has either (1) incurred or who family has incurred annual out-of-pocket costs at the hospital that exceed 10% of the patient's family income in the prior 12 months or (2) incurred or whose family has incurred annual out-of-pocket costs with other providers that exceed 10% of the patient's family income in the prior 12 months. Patients must provide documentation of out-of-pocket costs incurred at providers.

V. PROCEDURE:

Tenet standard accounting procedures should be followed to classify the accounts appropriately.

A. Factors to be Considered

Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published Federal Poverty Guideline (FPG), or an equivalent thereof. This information may be obtained through verbal means from the patient/guarantor and documented by either a specifically designated Tenet employee at the Tenet facility (such as a Patient Advocate, Financial Counselor) or Financial Assistance Processor, or other specifically designated Tenet employee after discharge.

Other factors may include, but are not limited to, the following:

1. Validate means of support if unemployed and no earned or unearned income have been provided on the application.

2. Validate activity on current accounts reported on credit bureau to determine how payments are being made if household expenses exceed income reported on Confidential Financial Statement.

3. Validate liquid assets (stocks, bonds, certificate of deposits, money market account, checking and saving balances)

4. The previous exhaustion of all other available resources.

5. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income if there is no surviving spouse or no other guarantor appears on the patient account. Although no documentation of income and no Confidential Financial Assistance Application are required for expired patients, the patient's financial status will be reviewed at the time of death by the Tenet Financial Assistance Center (TFAC) to ensure that a discount care adjustment is appropriate. TFAC will also determine whether the patient's estate or probate proceeding indicate liquid assets in excess of $10,000. If the value of the patient's estate or probate proceeding exceeds $10,001, the expired patient will not qualify for discount care. The estate will be pursued for reimbursement on debts owed.

6. Catastrophic illness and documented hardship within the household may also be considered for Charity Care.

B. Documentation

1. Confidential Financial Assistance Application

A Confidential Financial Assistance Application completed by the patient may not be required for patients who are deemed to be already eligible for other Federal, State, and County assistance programs. Such programs include, but are not limited to, Medicaid, County Assistance Programs, MIA, MSI, TANF, Food Stamps, and WIC.

In order to qualify for Charity Care, Tenet requires each patient or family to complete the Confidential Financial Assistance Application, refer to Attachment B attached to this policy. This application allows the collection of information about income and the documentation of other requirements as defined below.

a) Family Members – Tenet will require patients to provide the number of family members in their household.

(i) Adults – To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their dependent children under 21 years of age, whether living at home or not.

(ii) Minors – To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father, legal guardian and/or caretaker relative, and all of their other dependents under 21 years of age.

b) Income Calculation – Tenet requires patients to provide their household's annual gross income.

(i) Patient's Household Income – includes all funds received by all members of the patient's household that support the household.

a) Household – is defined as patient, patient's spouse or domestic partner, and all dependents living in the same residence as the patient and/or guarantor.

b) Dependent – is defined as a person who can be claimed by the guarantor and/or patient as a dependent on their federal tax return.

c) The Financial Assessment Processor will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

(i) IRS tax returns

(ii) Payroll stubs

(iii) Declarations

(iv) Verbal attestation

(v) Other forms used to substantiate the need for Charity Care consideration

(vi) Credit bureau report (including the lack thereof)

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by state law/regulation.

C. Appeal of Denied Charity Care Applications

The patient may appeal the charity denial by submitting additional documentation to substantiate the application and qualification to:

Attention: TFAC Manager
Tenet Financial Assistance Center
P.O. Box 66049
Anaheim, CA 92816-9908

1-888-233-7868

D. Reservation of Rights

It is the policy of Tenet and the hospital to reserve the right to limit or deny financial assistance at their sole discretion, consistent with Tenet and hospital policy and all applicable laws.

1. **Non-Covered Services**—It is the policy of Tenet and the hospital to reserve the right to designate certain services that are not subject to the hospital's Charity Care policy.

2. **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payors, patient transfers, emergency care, state-specific regulations, state-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

VI. ATTACHMENTS

A. Attachment A – Federal Poverty Guidelines

2007 FPG is as follows:

48 States Gross Yearly							
Size of Family	**100% of FPG**	**150% of FPG**	**200% of FPG**	**250% of FPG**	**300% of FPG**	**350% of FPG**	**400% of FPG**
1	10,210	15,315	20,420	25,525	29,400	35,735	40,840
2	13,690	20,535	27,380	34,225	39,600	47,915	54,760
3	17,170	25,755	34,340	42,925	49,800	60,095	68,680
4	20,650	30,975	41,300	51,625	60,000	72,275	82,600
5	24,130	36,195	48,260	60,325	70,200	84,455	96,520
6	27,610	41,415	55,220	69,025	80,400	96,635	110,440
7	31,090	46,635	62,180	77,725	90,600	108,815	124,360
8	34,570	51,855	69,140	86,425	100,800	120,995	138,280
Each additional person, add	3,480	5,220	6,690	8,700	10,200	12,180	13,920
Alaska Gross Monthly							
Size of Family	**100% of FPG**	**150% of FPG**	**200% of FPG**	**250% of FPG**	**300% of FPG**	**350% of FPG**	**400% of FPG**
1	12,770	19,155	25,540	31,925	36,750	44,695	51,080
2	17,120	25,680	34,240	42,800	49,500	59,920	68,480
3	21,470	32,205	42,940	53,675	62,250	75,145	85,880
4	25,820	38,730	51,640	64,550	75,000	90,370	103,280
5	30,170	45,255	60,340	75,425	87,750	105,595	120,680
6	34,520	51,780	69,040	86,300	100,500	120,820	138,080

7	38,870	58,305	77,740	97,175	113,250	136,045	155,480
8	43,220	64,830	86,440	108,050	126,000	151,270	172,880
Each additional person, add	4,350	6,525	8,700	10,875	12,750	15,225	17,400

Hawaii Gross Yearly							
Size of Family	**100% of FPG**	**150% of FPG**	**200% of FPG**	**250% of FPG**	**300% of FPG**	**350% of FPG**	**400% of FPG**
1	11,750	17,625	23,500	29,375	33,810	41,125	47,000
2	15,750	23,625	31,500	39,375	45,540	55,125	63,000
3	19,750	29,625	39,500	49,375	57,270	69,125	79,000
4	23,750	35,625	47,500	59,375	69,000	83,125	95,000
5	27,750	41,625	55,500	69,375	80,730	97,125	111,000
6	31,750	47,625	63,500	79,375	92,460	111,125	127,000
7	35,750	53,625	71,500	89,375	104,190	125,125	143,000
8	39,750	59,625	79,500	99,375	115,920	139,125	159,000
Each additional person, add	4,000	6,000	8,000	10,000	11,730	14,000	16,000

B. Attachment B – Confidential Financial Assistance Application

Tenet

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

EC ION

MEDICAL ASSISTANCE SCREENING – Please circle answer "Y" for yes or "N" for no.

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? If yes, does the patient have a 30-day incapacitation? Y / N
5. Is the patient pregnant, or was the admission pregnancy-related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

EC ION B

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household _______________

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father, Caretaker, and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_______________ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size

___________________________ ÷ ___________________________ = _______%

Type of Service (circle one) ER OP IP

Service Date _______________ to _______________

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:			Relationship to patient:
SSN:	DOB:		
Home Address:			Phone #:
Work Address:			Phone #:
Gross Income:	Check One: ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly		
	Hours Per Week:		
If income is $0/unemployed, what is your means of support?	Check One: ☐ Living on Savings/Annuity ☐ Live with parent/family/friends ☐ Homeless ☐ Shelter		

SPOUSE

Responsibility Party:			
SSN:	DOB:		
Home Address:			Phone #:
Work Address:			Phone #:
Gross Income:	Check One: ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly		
	Hours Per Week:		

HOMELESS AFFIDAVIT

I, ____________________________________, hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.

Patient/Guarantor Initials ______

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor and, in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that the Tenet Charity Care program is a “Payor of Last Resort” and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet’s or its subsidiaries provided care.

______________________________ __________

Patient/Guarantor Signature Date

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
Prepared by:		Date:	Unit:
Approved or Denied by:		Date:	Title:

Charity Care Policy – California

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation, its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of 50% or more; and (3) any hospital or healthcare facility in which Tenet or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tenet Facility") (collectively, "Tenet").

This policy applies to all Tenet California facilities.

II. PURPOSE:

To provide discounted healthcare to patients treated at Tenet California facilities that have a limited ability to pay for their care.

III. POLICY:

Tenet is committed to providing high quality, comprehensive health care services, regardless of a patient's ability to pay. Tenet strives to ensure that the financial situation of people who need health care services does not prevent them from seeking or receiving care. Discount care is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Tenet's procedures for obtaining financial assistance and to contribute to the cost of their care based on individual ability to pay.

The determination of discount care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the patient's ability to pay.

The discount amount is based on household income compared to the Federal Poverty Limit (FPL) for the current year. Uninsured or Under-insured patients (as defined below) with household income between 201% and 350% FPL will be eligible for care at a sliding scale discount.

Patients with family income under 200% FPL will be eligible for free care for the dates of service for which an application is completed. (Refer to RCPM Policy 02.06.02A for additional information.)

Uninsured patients whose family income exceeds 350% FPL will receive the Compact discounted rate. (Refer to RCPM Policy 02.02.09 for additional information.)

IV. DEFINITIONS:

A. Under-insured Patients

An "Under-insured Patient" is an insured patient with "high medical costs". These are insured patients whose family income does not exceed 350% of the FPL and has either (1) incurred or whose family has incurred annual out-of-pocket costs at the hospital that exceed 10% of the patient's family income in the prior 12 months or (2) incurred or whose family has incurred annual out-of-pocket costs with other providers that exceed 10% of the patient's family income in the prior 12 months. Patients must provide documentation of out-of-pocket costs incurred at providers.

V. PROCEDURE:

Tenet standard accounting procedures should be followed to classify the accounts appropriately.

A. Factors to be Considered

Factors to be considered in determining eligibility for discounted care must include comparing the patient's gross income to the annually published Federal Poverty Guideline (FPG), or an equivalent thereof. This information may be obtained through verbal means from the patient/guarantor and documented by a specifically designated Tenet employee at the Tenet facility (such as a Patient Advocate, Financial Counselor) or by a Financial Assistance Processor, or other Tenet employee after discharge.

Other factors may include, but are not limited to, the following:

1. Validate means of support if unemployed and no earned or unearned income have been provided on the Confidential Financial Assistance Application.

2. Validate activity on current accounts reported on credit bureau report to determine how payments are being made if household expenses exceed income reported on the Confidential Financial Assistance Application.

3. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income if there is no surviving spouse or no other guarantor appears on the patient account. Although no documentation of income and no Confidential Financial Assistance Application are required for expired patients, the patient's financial status will be reviewed at the time of death by the Tenet Financial Assistance Center (TFAC) to ensure that a discount care adjustment is appropriate. TFAC will also determine whether the patient's estate or probate proceeding indicate liquid assets in excess of $10,000. If the value of the patient's estate or probate proceeding exceeds $10,001, the expired patient will not qualify for discount care. The estate will be pursued for reimbursement on debts owed.

4. Catastrophic illness and documented hardship within the household may also be considered for Charity Care or discounted care.

B. Documentation

1. Confidential Financial Assistance Application

a) A Confidential Financial Assistance Application completed by the patient may not be required for patients who are deemed to be already eligible for other federal, state, and county assistance programs. Such programs include, but are not limited to, Medicaid, County Assistance Programs, MIA, MSI, TANF, Food Stamps, and WIC.

b) In order to qualify for discounted care, Tenet requires each patient or family to complete the Confidential Financial Assistance Application. This application allows the collection of information about income and the documentation of other requirements as defined below.

(i) Family Members—Tenet will require patients to provide the number of family members in their household.

a) Adults—To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their

dependents children under 21 years of age, whether living at home or not.

b) Minors—To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father, legal guardian and/or caretaker relative, and all of their other dependents under 21 years of age.

(ii) Income Calculation—Tenet requires patients to provide their household's annual gross income.

a) Patient's household income includes all funds received by all members of the patient's household that support the household.

b) Household is defined as patient, patient's spouse or domestic partner, and all dependents living in the same residence as the patient and/or guarantor.

c) A dependent is defined as a person who can be claimed by the guarantor and/or patient as a dependent on their federal tax return.

c) The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

(i) IRS tax returns

(ii) Payroll stubs

(iii) Declarations

(iv) Verbal attestation

(v) Other forms used to substantiate the need for Discount Care consideration

(vi) Credit bureau report (including the lack thereof)

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by state law/regulation.

C. Appeal of Denied Discounted Care Applications

The patient may appeal the charity denial by submitting additional documentation to substantiate the application and qualification to:

Attention: TFAC Manager
Tenet Financial Assistance Center
P.O. Box 66049
Anaheim, CA 92816-9908
1-888-233-7868

D. Reservation of Rights

It is the policy of Tenet and the hospital to reserve the right to limit or deny financial assistance at their sole discretion, consistent with Tenet and hospital policy and all applicable laws.

1. **Non-Covered Services**—It is the policy of Tenet and the hospital to reserve the right to designate certain services as not subject to the hospital's Discount Care policy.

2. **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payors, patient transfers, emergency care, state-specific regulations, state-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

VI. Attachments

A. Attachment A – Federal Poverty Guidelines

2007 FPG is as follows:

48 States Gross Yearly							
Size of Family	100% of FPG	150% of FPG	200% of FPG	250% of FPG	300% of FPG	350% of FPG	400% of FPG
1	10,210	15,315	20,420	25,525	29,400	35,735	40,840
2	13,690	20,535	27,380	34,225	39,600	47,915	54,760
3	17,170	25,755	34,340	42,925	49,800	60,095	68,680
4	20,650	30,975	41,300	51,625	60,000	72,275	82,600
5	24,130	36,195	48,260	60,325	70,200	84,455	96,520
6	27,610	41,415	55,220	69,025	80,400	96,635	110,440
7	31,090	46,635	62,180	77,725	90,600	108,815	124,360
8	34,570	51,855	69,140	86,425	100,800	120,995	138,280
Each additional person, add	3,480	5,220	6,690	8,700	10,200	12,180	13,920
Alaska Gross Monthly							
Size of Family	100% of FPG	150% of FPG	200% of FPG	250% of FPG	300% of FPG	350% of FPG	400% of FPG
1	12,770	19,155	25,540	31,925	36,750	44,695	51,080
2	17,120	25,680	34,240	42,800	49,500	59,920	68,480
3	21,470	32,205	42,940	53,675	62,250	75,145	85,880
4	25,820	38,730	51,640	64,550	75,000	90,370	103,280
5	30,170	45,255	60,340	75,425	87,750	105,595	120,680
6	34,520	51,780	69,040	86,300	100,500	120,820	138,080
7	38,870	58,305	77,740	97,175	113,250	136,045	155,480
8	43,220	64,830	86,440	108,050	126,000	151,270	172,880
Each additional person, add	4,350	6,525	8,700	10,875	12,750	15,225	17,400

Hawaii Gross Yearly							
Size of Family	**100% of FPG**	**150% of FPG**	**200% of FPG**	**250% of FPG**	**300% of FPG**	**350% of FPG**	**400% of FPG**
1	11,750	17,625	23,500	29,375	33,810	41,125	47,000
2	15,750	23,625	31,500	39,375	45,540	55,125	63,000
3	19,750	29,625	39,500	49,375	57,270	69,125	79,000
4	23,750	35,625	47,500	59,375	69,000	83,125	95,000
5	27,750	41,625	55,500	69,375	80,730	97,125	111,000
6	31,750	47,625	63,500	79,375	92,460	111,125	127,000
7	35,750	53,625	71,500	89,375	104,190	125,125	143,000
8	39,750	59,625	79,500	99,375	115,920	139,125	159,000
Each additional person, add	4,000	6,000	8,000	10,000	11,730	14,000	16,000

B. Attachment B – Confidential Financial Assistance Application

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

EC ION

MEDICAL ASSISTANCE SCREENING – Please circle answer "Y" for yes or "N" for no.

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? Y / N
   If yes, does the patient have a 30-day incapacitation?
5. Is the patient pregnant, or was the admission pregnancy-related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

EC ION B

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household _______________

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father, Caretaker, and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_______________ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size

___________________________ ÷ ___________________________ = _______%

Type of Service (circle one) ER OP IP
Service Date _______________ to _______________

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient:
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income:	Check One: ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	Check One: ☐ Living on Savings/Annuity ☐ Live with parent/family/friends ☐ Homeless ☐ Shelter	

SPOUSE

Responsible Party:		
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income:	Check One: ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	

HOMELESS AFFIDAVIT

I, ______________________________________, hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.

Patient/Guarantor Initials ______

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor and, in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that the Tenet Charity Care program is a "Payor of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet's or its subsidiaries provided care.

____________________________ __________

Patient/Guarantor Signature Date

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
Prepared by:		Date:	Unit:
Approved or Denied by:		Date:	Title:

Exhibit VI ECHN's Policies and Procedures for Financial Assistance/Charity care

TITLE: Financial Assistance / Charity Care Policy: 500

TOPIC

Financial Assistance / Charity Care

ECHN is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate those who are poor and disenfranchised, ECHN strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

PURPOSE

To identify those patients that qualify for charitable assistance and to complete write-off procedures that are in keeping with state and federal regulations.

A. ECHN is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
B. It is the policy of ECHN to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy is to describe how applications for Federal Assistance should be made, the criteria for eligibility, and the steps for processing each application.
C. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financials Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.
D. Race, gender, sexual orientation, religious or political affiliation, social or immigration status will not be taken into consideration.
E. To further ECHN's commitment to their mission to provide healthcare to patients seeking emergency care, ECHN will utilize an abbreviated application for financial assistance for their uninsured patients being seen in the Emergency Room. The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active medical assistance coverage.

POLICY:

In order to provide the level of aid necessary to the greatest number of patients in need, and protect the resources needed to do so, the following guidelines apply:

A. Patient
    a. Services are provided under charity care only when deemed medically necessary and after patients are found to have met all financial criteria based on the disclosure of proper information and documentation.
    b. Any patient who believes that they are qualified may apply for financial assistance under the hospitals' charity care policy or discount policy.
    c. Patients are expected to contribute payment for care based on their individual financial situation; therefore, each case will be reviewed separately.
    d. Charity Care is not considered an alternative option to payment and patients may be assisted in finding other means of payment or financial assistance before approval for charity care.

e. Uninsured patients who are believed to have the financial ability to purchase health insurance may be encourage to do so in order to ensure healthcare accessibility and overall well-being.

B. Hospital

a. ECHN will maintain an understandable, written financial assistance policy, clearly stating the eligibility criteria.
b. ECHN will ensure that all financial assistance policies will be applied consistently.
c. In applying the Financial Assistance policy, ECHN will assist the patent in determining if he/she is eligible for government- sponsored programs.

C. COMMUNICATION:

a. Notices regarding availability of Charity Care at ECHN will be posted in public places around the hospital, on patient bills, and on our website.

PROCEDURE

a. Services Eligible Under This Policy
   i. The following healthcare services are eligible for charity:
      1. Emergency medical services provided in an emergency room setting;
      2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
      3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
      4. Medically necessary services, evaluated on a case-by-case basis at ECHN's discretion.
b. Eligibility for Charity Care
      1. Eligibility for Charity Care will be based on an individuals assessment of financial need.
      2. Requires an application process.
      3. We expect cooperation from patients and guardians.
      4. May rely upon publicly available information and resources to determine the financial resources of the patient or a potential guardian.
      5. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
      6. The need for financial assistance shall be re-evaluated every six months or at any time additional information relevant to the eligibility of the patient for charity care becomes known.

c. Presumptive Financial Assistance Eligibility
   i. There are instances when a patient may appear eligible for charity care discounts, but are unable to provide supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance such as
      1. State-funded prescription programs;
      2. Patient is homeless or received care from a homeless clinic;
      3. Patient files bankruptcy
      4. Participation in Women, Infants and Children programs (WIC);
      5. Patient is eligible for assistance under the Crime Victims Act or Sexual Assault Act
      6. Food stamp eligibility;
      7. Subsidized school lunch program eligibility;
      8. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
      9. Low income/subsidized housing is provided as a valid address; and
      10. Patient is deceased with no known estate.

D. ASSESSMENT PROCESS

1. The application must be fully completed and signed by the patient / responsible party
2. Proof of income for applicant (and spouse if applicable) is verified by two forms of documentation which could include:
    a. Last four pay stubs
    b. Previous Year Federal Income Tax Form
    c. Previous Year W-2 Form
    d. Social Security Statement
    e. Unemployment Benefit Statement
3. Other documentation that may be required:
    a. Proof of disability compensation
    b. For Medicare patients a copy of their social security benefits, pension and retirement benefits and/or bank statements showing deposits
    c. Workers compensation deposits

i. The level of Charity Care provided will be determined based on the Federal Poverty Level in effect (please refer to the current year's sliding scale).

ii. Once a patient has been granted financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

E. PRESUMPTIVE PRACTICES FOR CHARITY CARE PATIENTS

a. Internal and external collection policies and procedures will take into account the extent to which a patient is qualified for charity care or discounts. In additional, patients who qualify for partial discounts are required to make a good faith effort to honor payment agreements with ECHN, including payment plans and discounted hospital bills. ECHN is committed to working with patients to resolve their accounts, and at its discretion, may provide extended payment plans to eligible patients. ECHN will not pursue legal action for non-payment of bills against charity care patients who have cooperated with the hospital to resolve their accounts and have demonstrated their income and/or assets are insufficient to pay medical bills.

b. During the eligibility process, other forms of financial assistance will be considered such as Medicare and Medicaid.

DEFINITIONS

The following terms are meant within this policy to be interpreted as follows:

a. Charity Care means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in the hospital's charity care policies on file at OCHA.

b. Emergency Care: Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any organs or parts.

c. Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal revenue Services rules, if the patient claims someone as a dependant on their income tax return, they may be considered a dependent for purposed of the provision of financial assistance.

d. Family Income: family income is determined using the census Bureau definition, which uses the following income when computing federal poverty guidelines.
    i. Includes earnings, unemployment compensation, workers' compensation, Social security, Supplemental security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income form estates, trusts, educational assistance, alimony, child support, assistance form outside the household, and other miscellaneous sources.
    ii. Noncash benefits (such as food stamps and housing subsidies) do not count.
    iii. Determined on a before-tax basis
    iv. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates do not count)

e. Medically Necessary: hospital services or care rendered (both inpatient and outpatient) to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
f. Presumptive: other financial assistance, not charity care.
g. Underinsured: Patients who carry insurance of have third party assistance to help pay for medical services, but who accrue or have the likelihood of accruing out-of-pocket expenses which exceed their financial ability.
h. Uninsured: means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified an uninsured patient, is such subsequent reimbursement takes place.
i. Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if treated within 12 hours.

ATTACHMENTS: A

INDIVIDUAL RESPONSIBLE FOR REVISION: Director Patient Financial Services

ORIGINATED: 07/29/02 REVISION DATE: 8/1/05
8/3/07
9/20/10
11/26/12
04/15/13

Notice of Availability for Uncompensated Care

Eastern Connecticut Health Network, Inc. will provide assistance for those patients who fall within the guidelines below**.**

To be eligible to receive uncompensated care, your family must be at or below the following current guidelines.

Family Gross Income Levels

2014 Federal Po ert uidelines	125%	150%	175%	200%	250%	300%	400%
% of Write Off	100%	90%	80%	70%	60%	50%	40%
Family Size							
1	14,588	17,505	20,423	23,340	29,175	35,010	46,680
2	19,663	23,595	27,528	31,460	39,325	47,190	62,920
3	24,738	29,685	34,633	39,580	49,475	59,370	79,160
4	29,813	35,775	41,738	47,700	59,625	71,550	95,400
5	34,888	41,865	48,843	55,820	69,775	83,730	111,640
6	39,963	47,955	55,948	63,940	79,925	95,910	127,880
7	45,038	54,045	63,053	72,060	90,075	108,090	144,120
8	50,113	60,135	70,158	80,180	100,225	120,270	160,360

Add $4,060 for each additional member

Patient Responsibility	0%	10%	20%	30%	40%	50%	60%

If you feel you may be eligible, you may request free or discounted services at the Patient Financial Service Office. Requests may be made prior to admission, during the stay or at time of discharge. A financial evaluation form and application will be provided for the applicant upon request. The Hospital will make a final determination of your eligibility for uncompensated services.

When Third Party coverage is available (Medicare, State, Medicaid LIA, etc) all applicable benefits must be applied first. Patient convenience items such as private room differentials are not covered.

Refusal to take reasonable actions necessary to obtain these available benefits can exclude the granting of uncompensated services.

Source – Federal Register Income Poverty Guidelines

Exhibit VII ECHN 5 Year Pro Forma – Impact of HIE

ECHN
5 YE P O FO
FY 2011 FY 2015

INCO E E EN

	FY 2011	Projected FY 2012	Projected FY 2013	Projected FY 2014	Projected FY 2015
Net Patient e enue	$258,675,559	$270,062,457	$286,002,457	$289,023,707	$297,743,301
Operating Expenses					
alaries/ emporar Help	$133,507,564	$135,869,603	$139,430,691	$143,613,612	$147,922,020
Fringe Bene its	$36,841,252	$39,555,692	$42,333,476	$43,700,150	$44,160,158
upplies	$79,853,207	$82,329,649	$84,799,539	$87,343,525	$89,963,831
Ph sician Fees	$9,559,006	$9,627,842	$9,916,677	$10,214,178	$10,520,603
epreciation	$11,948,869	$12,500,000	$12,750,000	$13,000,000	$13,250,000
Interest	$4,278,144	$4,250,000	$4,300,000	$4,200,000	$4,200,000
Bad e t	$10,234,830	$10,227,684	$10,500,000	$11,000,000	$11,500,000
otal Operating Expenses	**$286,222,872**	**$294,360,470**	**$304,030,384**	**$313,071,465**	**$321,516,612**
Other Operating e enue	$23,947,138	$25,504,509	$22,149,644	$25,314,134	$25,075,737
oint enture Income	$2,496,570	$2,548,545	$2,612,259	$2,677,565	$2,744,504
Interest Income	$1,103,606	$1,072,959	$1,100,000	$1,150,000	$1,200,000
Net Operating Income/ oss	**$0**	**$4,828,000**	**$7,833,976**	**$5,093,941**	**$5,246,930**
Net Operating argin		1.6%	2.5%	1.6%	1.6%
Net Operating Income 3		$8,975,654	$9,355,931	$9,544,962	$9,802,906
Estimated Impact o HIE at edicare ates	**$0**	**$0**	**$0**	**$9,500,000**	**$9,500,000**
See Determination of HIE Impact at Government Rates worksheet for derivation of projected impact					
Net Income hort all esulting rom HIE	**$0**	**$0**	**$0**	**$4,406,059**	**$4,253,070**
Estimated Impact o HIE at edicaid ates	**$0**	**$0**	**$0**	**$11,000,000**	**$11,000,000**
See Determination of HIE Impact at Government Rates worksheet for derivation of projected impact					
Net Income hort all esulting rom HIE	**$0**	**$4,828,000**	**$7,833,976**	**$5,906,059**	**$5,753,070**

etermination o HIE Impact at o ernment ates

HIE = Health Insurance Exchange

	Be ore Implementation o the HIE		ter Implementation o the Health Insurance Exchange			
Pa er Categor	**ross Charges [1]**	**Charges ix Pa er Categor**	**Projected Charges ix**	**Projected ross Charges**	**eallocation o ross Charges**	**Change in ross Charges Pa er**
edicare	245,100,000	43%	43%	245,100,000	0	
edicaid	91,200,000	16%	20%	114,000,000	22,800,000	25%
anaged Care	216,600,000	38%	31%	176,700,000	(39,900,000)	-18%
el Pa	17,100,000	3%	1%	5,700,000	(11,400,000)	-67%
Exchange	0	0%	5%	28,500,000	28,500,000	
otal ross Charges	**570,000,000**			**570,000,000**	**0**	

HIE at edicare ates	Be ore Implementation o the HIE		ter Implementation o the Health Insurance Exchange		
Pa er Categor	**Net e enue**	**Net e enue as a o ross Charges**	**Projected Net e enue**	**Projected Net e enue ain/ oss**	**Percent Change in Net e enue**
edicare	79,500,000	32%	79,500,000	0	
edicaid	24,250,000	27%	30,312,500	6,062,500	
anaged	132,823,800	61%	108,356,258	(24,467,542)	
el Pa	540,000	3%	180,000	(360,000)	
Exchange [2]	0	0%	9,244,186	9,244,186	
otal Net e enue	**237,113,800**		**227,592,944**	(9,520,856)	**4 0**

HIE at edicaid ates	Be ore Implementation o the HIE		ter Implementation o the Health Insurance Exchange		
Pa er Categor	**Net e enue**	**Net e enue as a o ross Charges**	**Projected Net e enue**	**Projected Net e enue ain/ oss**	**Percent Change in Net e enue**
edicare	79,500,000	32%	79,500,000	0	
edicaid	24,250,000	27%	30,312,500	6,062,500	
anaged	132,823,800	61%	108,356,258	(24,467,542)	
el Pa	540,000	3%	180,000	(360,000)	
Exchange [3]	0	0%	7,578,125	7,578,125	
otal Net e enue	**237,113,800**		**225,926,883**	(11,186,917)	**4 7**

(1) Based on FY 2011 estimated gross charges and payer mix for MMH and RGH
(2) Exchange net revenue as a percent of gross charges will be the same as the current Medicare experience (reimbursement at 32% of gross charges)
(3) Exchange net revenue as a percent of gross charges will be the same as the current Medicaid experience (reimbursement at 27% of gross charges)

Exhibit VIII YNHHS Hospital Compare Reports

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Medicare.gov | Hospital Compare

The Official U.S. Government Site for Medicare

General information

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000
Hospital type	Acute Care Hospitals	Acute Care Hospitals	Acute Care Hospitals
Provides emergency services	Yes	Yes	Yes
Able to receive lab results electronically	Yes	No	Yes

Able to track patients' lab results, tests, and referrals electronically between visits	No	No	Yes
Uses a safe surgery checklist	Yes	Yes	Yes

Survey of patients' experiences

Survey of patients' experiences

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on ten important hospital quality topics.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Patients who reported that their nurses "Always" communicated well	81%	80%	81%	78%	79%

Patients who reported that their doctors "Always" communicated well	80%	79%	82%	80%	82%
Patients who reported that they "Always" received help as soon as they wanted	65%	65%	71%	64%	68%
Patients who reported that their pain was "Always" well controlled	73%	67%	77%	71%	71%
Patients who reported that staff "Always" explained about medicines before giving it to them	60%	60%	64%	62%	64%
Patients who reported that their room and bathroom were "Always" clean	67%	68%	80%	71%	73%
Patients who reported that the area around their room was "Always" quiet at night	45%	51%	57%	52%	61%
Patients who reported that YES, they were given information about what to do during their recovery at home	82%	85%	82%	85%	85%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	66%	71%	83%	68%	71%
Patients who reported YES, they would definitely recommend the hospital	75%	76%	85%	71%	71%

Timely & effective care

Timely & effective care

These measures show how often hospitals provide care that research shows gets the best results for patients with certain conditions. This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

Heart attack care

An acute myocardial infarction (AMI)—or heart attack—happens when one of the heart's arteries becomes blocked and the supply of blood and oxygen to part of the heart muscle is slowed or stopped. When the heart muscle doesn't get the oxygen and nutrients it needs, the affected heart tissue may die. These measures show some of recommended treatments provided, if appropriate, for most adults who have had a heart attack.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely heart attack care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital *A **lower** number of minutes is better*	Not Available[5]	Not Available[5]	Not Available[5]	61 Minutes	60 Minutes
Average number of minutes before outpatients with chest pain or possible heart attack got an ECG *A **lower** number of minutes is better*	Not Available[5]	Not Available[5]	Not Available[5]	7 Minutes	7 Minutes
Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival ***Higher** percentages are better*	Not Available[5]	Not Available[5]	Not Available[5]	33%	58%
Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival ***Higher** percentages are better*	Not Available[5]	Not Available[5]	Not Available[5]	98%	96%
Heart attack patients given drugs to break up blood clots within 30 minutes of arrival ***Higher** percentages are better*	Not Available[2,7]	Not Available[2,7]	Not Available[2,7]	50%	54%

Heart attack patients given PCI within 90 minutes of arrival ***Higher*** *percentages are better*	94%[2]	97%[2]	100%[2]	96%	96%

Effective heart attack care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Heart attack patients given aspirin at discharge ***Higher*** *percentages are better*	98%[2]	99%[2]	98%[2]	99%	99%
Heart attack patients given a prescription for a statin at discharge ***Higher*** *percentages are better*	98%[2]	98%[2]	100%[2]	98%	98%

Heart failure care

Heart failure is a weakening of the heart's pumping power. With heart failure, your body doesn't get enough oxygen and nutrients to meet its needs. These measures show some of the recommended treatments provided for most adults with heart failure.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Effective heart failure care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Heart failure patients given discharge instructions ***Higher*** *percentages are better*	96%[2]	92%[2]	98%[2]	93%	94%
Heart failure patients given an evaluation of left ventricular systolic (LVS) function ***Higher*** *percentages are better*	99%[2]	100%[2]	100%[2]	100%	99%
Heart failure patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD) ***Higher*** *percentages are better*	92%[2]	91%[2]	96%[2]	96%	97%

Pneumonia care

Pneumonia is a serious lung infection that causes difficulty breathing, fever, cough and fatigue. These measures show some of the recommended treatments for pneumonia.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Effective pneumonia care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics ***Higher*** *percentages are better*	92%[2]	95%[2]	99%[2]	97%	98%
Pneumonia patients given the most appropriate initial antibiotic(s) ***Higher*** *percentages are better*	90%[2]	99%[2]	97%[2]	97%	95%

Surgical care

Hospitals can reduce the risk of infection after surgery by making sure they provide care that's known to get the best results for most patients, including:

- Giving the recommended antibiotics at the right time before surgery;
- Stopping the antibiotics within the right timeframe after surgery;
- Maintaining the patient's temperature and blood glucose (sugar) at normal levels; and
- Removing catheters that are used to drain the bladder in a timely manner after surgery.

Hospitals can also reduce the risk of cardiac problems associated with surgery by:

- Making sure that certain prescription drugs are continued in the time before, during, and just after the surgery. This includes drugs used to control heart rhythms and blood pressure.
- Giving drugs that prevent blood clots and using other methods such as special stockings that increase circulation in the legs.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely surgical care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) ***Higher*** *percentages are better*	98%	95%	98%	97%	98%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection ***Higher*** *percentages are better*	99%[2]	97%[2]	99%[2]	98%	99%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) ***Higher*** *percentages are better*	98%[2]	99%[2]	94%[2]	98%	98%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery ***Higher*** *percentages are better*	99%[2]	100%[2]	97%[2]	99%	98%

Effective surgical care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Outpatients having surgery who got the right kind of antibiotic ***Higher*** *percentages are better*	97%	85%	98%	97%	98%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery ***Higher*** *percentages are better*	98%[2]	100%[2]	100%[2]	98%	98%
Surgery patients who were given the right kind of antibiotic to help prevent infection ***Higher*** *percentages are better*	99%[2]	99%[2]	98%[2]	99%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery ***Higher*** *percentages are better*	95%[2]	94%[2]	Not Available[2,7]	96%	97%
Surgery patients whose urinary catheters were removed on the first or second day after surgery ***Higher*** *percentages are better*	96%[2]	96%[2]	96%[2]	97%	97%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery ***Higher*** *percentages are better*	99%[2]	96%[2]	100%[2]	99%	100%

Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delays before receiving care in the emergency department can reduce the quality of care and increase risks and discomfort for patients with serious illnesses or injuries. Waiting times at different hospitals can vary widely, depending on the number of patients seen, staffing levels, efficiency, admitting procedures, or the availability of inpatient beds.

The information below shows how quickly the hospitals you selected treat patients who come to the hospital emergency department, compared to the average for all hospitals in the U. S.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely emergency department care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Average time patients spent in the emergency department, before they were admitted to the hospital as an inpatient *A **lower** number of minutes is better*	438 Minutes[2]	301 Minutes[2]	276 Minutes[2]	338 Minutes	274 Minutes
Average time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A **lower** number of minutes is better*	206 Minutes[2]	100 Minutes[2]	136 Minutes[2]	147 Minutes	98 Minutes
Average time patients spent in the emergency department before being sent home *A **lower** number of minutes is better*	182 Minutes	190 Minutes	133 Minutes	131 Minutes	134 Minutes

Average time patients spent in the emergency department before they were seen by a healthcare professional *A **lower** number of minutes is better*	79 Minutes	45 Minutes	31 Minutes	28 Minutes	26 Minutes
Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication *A **lower** number of minutes is better*	70 Minutes	50 Minutes	53 Minutes	55 Minutes	57 Minutes
Percentage of patients who left the emergency department before being seen ***Lower** percentages are better*	3%	4%	0%	2%	2%
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival ***Higher** percentages are better*	Not Available[1,3]	Not Available[5]	Not Available[1,3]	70%	57%

Preventive care

Hospitals and other healthcare providers play a crucial role in promoting, providing and educating patients about preventive services and screenings and maintaining the health of their communities. Many diseases are preventable through immunizations, screenings, treatment, and lifestyle changes. The information below shows how well the hospitals you selected are providing preventive services.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Patients assessed and given influenza vaccination ***Higher*** *percentages are better*	91%[2]	65%[2]	65%[2]	90%	90%
Patients assessed and given pneumonia vaccination ***Higher*** *percentages are better*	91%[2]	68%[2]	72%[2]	91%	92%

Children's asthma care

Asthma is a chronic lung condition that causes problems getting air in and out of the lungs. Children with asthma may experience wheezing, coughing, chest tightness and trouble breathing.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Effective children's asthma care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Children who received reliever medication while hospitalized for asthma ***Higher** percentages are better*	Not Available	100%[2]	Not Available	Not Available	100%
Children who received systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma ***Higher** percentages are better*	Not Available	99%[2]	Not Available	Not Available	100%
Children and their caregivers who received a home management plan of care document while hospitalized for asthma ***Higher** percentages are better*	Not Available	63%[2]	Not Available	Not Available	88%

Stroke care

A stroke, sometimes called a "brain attack," occurs when blood flow to the brain is interrupted. When a stroke occurs, brain cells in the immediate area begin to die because they stop getting the oxygen and nutrients they need to function. There are two major kinds of stroke:

An ischemic stroke is caused by a blood clot that blocks or plugs a blood vessel or artery in the brain.

A hemorrhagic stroke is caused by a blood vessel in the brain that breaks and bleeds into the brain.

Strokes can cause a loss of the ability to speak, memory problems, or paralysis on one side of the body. Getting the right care at the right time can help reduce the risk of complications and another stroke. These measures show some of the standards of stroke care that hospitals should follow, for adults who have had a stroke.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely stroke care

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started ***Higher*** *percentages are better*	92%[2]	Not Available[1,2]	Not Available[1,2]	71%	66%
Ischemic stroke patients who received medicine known to prevent complications caused by blood clots within 2 days of arriving at the hospital ***Higher*** *percentages are better*	100%[2]	100%[2]	100%[2]	99%	98%
Ischemic or hemorrhagic stroke patients who received treatment to keep blood clots from forming anywhere in the body within 2 days of arriving at the hospital ***Higher*** *percentages are better*	99%[2]	97%[2]	98%[2]	95%	94%

Effective stroke care

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	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Ischemic stroke patients who received a prescription for medicine known to prevent complications caused by blood clots before discharge ***Higher*** *percentages are better*	96%[2]	100%[2]	99%[2]	99%	99%
Ischemic stroke patients with a type of irregular heartbeat who were given a prescription for a blood thinner at discharge ***Higher*** *percentages are better*	83%[2]	Not Available[1,2]	100%[2]	96%	95%
Ischemic stroke patients needing medicine to lower cholesterol, who were given a prescription for this medicine before discharge ***Higher*** *percentages are better*	90%[2]	96%[2]	98%[2]	95%	94%
Ischemic or hemorrhagic stroke patients or caregivers who received written educational materials about stroke care and prevention during the hospital stay ***Higher*** *percentages are better*	90%[2]	58%[2]	91%[2]	80%	88%
Ischemic or hemorrhagic stroke patients who were evaluated for rehabilitation services ***Higher*** *percentages are better*	99%[2]	100%[2]	100%[2]	98%	97%

Blood clot prevention and treatment

Because hospital patients often have to stay in bed for long periods of time, any patient who is admitted to the hospital is at increased risk of developing a blood clot in the veins (known as venous thromboembolism). Blood clots can break off and travel to other parts of the body and cause serious problems, even death. Fortunately, there are safe, effective, and proven methods to prevent blood clots or to treat them when they occur.

The measures listed below show how well hospitals are providing recommended care known to prevent or treat blood clots and how often blood clots occur that could have been prevented.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Blood clot prevention

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Patients who got treatment to prevent blood clots on the day of or day after hospital admission or surgery ***Higher*** *percentages are better*	93%[2]	90%[2]	83%[2]	89%	85%
Patients who got treatment to prevent blood clots on the day of or day after being admitted to the intensive care unit (ICU) ***Higher*** *percentages are better*	100%[2]	89%[2]	98%[2]	93%	92%
Patients who developed a blood clot while in the hospital who *did not* get treatment that could have prevented it ***Lower*** *percentages are better*	6%[2]	4%[2]	Not Available[1,2]	6%	10%

Blood clot treatment

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	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Patients with blood clots who got the recommended treatment, which includes using two different blood thinner medicines at the same time ***Higher*** *percentages are better*	79%[2]	94%[2]	96%[2]	91%	93%
Patients with blood clots who were treated with an intravenous blood thinner, and then were checked to determine if the blood thinner was putting the patient at an increased risk of bleeding ***Higher*** *percentages are better*	98%[2]	94%[2]	100%[2]	95%	97%
Patients with blood clots who were discharged on a blood thinner medicine and received written instructions about that medicine ***Higher*** *percentages are better*	59%[2]	73%[2]	11%[2]	64%	75%

Pregnancy and delivery care

By providing care to pregnant women that follows best practices, hospitals and doctors can improve chances for a safe delivery and a healthy baby.

This measure shows the percentage of pregnant women who had elective deliveries 1-3 weeks early (either vaginally or by C-section) whose early deliveries were not medically necessary. Higher numbers may indicate that hospitals aren't doing enough to discourage this unsafe practice.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Percent of newborns whose deliveries were scheduled too early (1-3 weeks early), when a scheduled delivery was not medically necessary ***Lower*** *percentages are better*	10%[2]	10%[2]	13%[2]	5%	6%

Readmissions, complications, & deaths

Readmissions, complications, and deaths

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

30-day outcomes: Unplanned readmission and death rates

Measures of 30-day unplanned readmission show when patients who have had a recent hospital stay need to go back into a hospital again for unplanned care within 30 days of their initial discharge.

Measures of 30-day death (mortality) show when patients die, for any reason, within 30 days of admission to a hospital.

Below, each hospital's performance on the death (mortality) and unplanned readmission measures is compared to the U.S. national observed rates for those measures. The performance results take into account how sick patients were before they were admitted to the hospital.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	U.S. NATIONAL RATE
Rate of unplanned readmission for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	18.3%
Death rate for heart attack patients	No Different than U.S. National Rate	Better than U.S. National Rate	No Different than U.S. National Rate	15.2%
Rate of unplanned readmission for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	23.0%
Death rate for heart failure patients	No Different than U.S. National Rate	Better than U.S. National Rate	No Different than U.S. National Rate	11.7%
Rate of unplanned readmission for pneumonia patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	17.6%
Death rate for pneumonia patients	No Different than U.S. National Rate	Better than U.S. National Rate	No Different than U.S. National Rate	11.9%
Rate of unplanned readmission after hip/knee surgery	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	5.4%
Rate of unplanned readmission after discharge from hospital (hospital-wide)	Worse than U.S. National Rate	Worse than U.S. National Rate	No Different than U.S. National Rate	16.0%

Surgical complications

This section shows serious complications that patients with Original Medicare (traditional fee-for-service Medicare) experienced during a hospital stay or after having certain inpatient surgical procedures. These complications can often be prevented if hospitals follow procedures based on best practices and scientific evidence.

Find out why these measures are important.

Get more information about the hip/knee data.

Get more information about the AHRQ data.

Get the current data collection period.

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	U.S. NATIONAL RATE
Rate of complications for hip/knee replacement patients	Worse than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	3.4%
Serious complications (From AHRQ)	Worse than U.S. National Rate	Worse than U.S. National Rate	No Different than U.S. National Rate	0.61
Deaths among patients with serious treatable complications after surgery (From AHRQ)	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate	110.25 per 1,000 patient discharges

Healthcare-associated infections

Healthcare-associated infections, or HAIs, are infections that people get while they are receiving treatment for another condition in a healthcare setting. HAIs can occur in all settings of care, including acute care hospitals, long term acute care hospitals, rehabilitation facilities, surgical centers, cancer hospitals, and skilled nursing facilities. Many of these infections can be prevented through the use of proper procedures and precautions. Below, different HAIs for each hospital are compared to the U.S. benchmark.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000
Central line-associated bloodstream infections (CLABSI)	No Different than U.S. National Benchmark	Better than the U.S. National Benchmark	No Different than U.S. National Benchmark
Catheter-associated urinary tract infections (CAUTI)	No Different than U.S. National Benchmark	Worse than the U.S. National Benchmark	No Different than U.S. National Benchmark
Surgical site infections from colon surgery (SSI: Colon)	No Different than U.S. National Benchmark	No Different than U.S. National Benchmark	No Different than U.S. National Benchmark
Surgical site infections from abdominal hysterectomy (SSI: Hysterectomy)	Worse than the U.S. National Benchmark	Worse than the U.S. National Benchmark	No Different than U.S. National Benchmark
Methicillin-resistant *Staphylococcus Aureus* (MRSA) Blood Laboratory-identified Events (Bloodstream infections)	No Different than U.S. National Benchmark	No Different than U.S. National Benchmark	No Different than U.S. National Benchmark
***Clostridium difficile* (C.diff.) Laboratory-identified Events (Intestinal infections)**	No Different than U.S. National Benchmark	Worse than the U.S. National Benchmark	Better than the U.S. National Benchmark

American College of Cardiology percutaneous coronary intervention (PCI) readmission measure

The PCI readmission measure compares hospitals based on unplanned readmissions that occur within 30 days of hospital discharge following a PCI procedure. Get PCI readmission data and learn more about this voluntarily reported measure.

Use of medical imaging

Use of medical imaging

These measures give you information about hospitals' use of medical imaging tests (like mammograms, MRIs, and CT scans) for outpatients based on the following:

- Protecting patients' safety, such as keeping patients' exposure to radiation and other risks as low as possible;
- Following up properly when screening tests such as mammograms show a possible problem; and

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- Avoiding the risk, stress, and cost of doing imaging tests that patients may not need.

The information shown here is limited to medical imaging facilities that are part of a hospital or associated with a hospital. These facilities can be inside or near the hospital, or in a different location. This information only includes medical imaging done on outpatients. It does not include medical imaging tests done for patients who have been admitted to the hospital as inpatients.

These measures are based on Medicare claims data.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	X BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	X YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	X GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000	CONNECTICUT AVERAGE	NATIONAL AVERAGE
Outpatients with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.) ***Lower** percentages are better*	Not Available[1]	34.4%	40.2%	34.3%	37.2%
Outpatients who had a follow-up mammogram, ultrasound, or MRI of the breast within 45 days after a screening mammogram (A follow-up rate near zero may indicate missed cancer; a rate higher than 14% may mean there is unnecessary follow up.)	23.2%	13.5%	21.8%	19.5%	8.8%

Outpatient CT scans of the chest that were "combination" (double) scans (If a number is high, it may mean that too many patients are being given a double scan when a single scan is all they need.) ***Lower*** *percentages are better*	12.2%	0.4%	0.3%	0.9%	2.7%
Outpatient CT scans of the abdomen that were "combination" (double) scans (If a number is high, it may mean that too many patients are being given a double scan when a single scan is all they need.) ***Lower*** *percentages are better*	13.4%	6.3%	5.1%	5.0%	10.5%
Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery (If a number is high, it may mean that too many cardiac scans were done prior to low-risk surgeries.) ***Lower*** *percentages are better*	4.6%	4.6%	6.8%	4.7%	5.3%
Outpatients with brain CT scans who got a sinus CT scan at the same time (If a number is high, it may mean that too many patients are being given both a brain and sinus scan, when a single scan is all they need.) ***Lower*** *percentages are better*	Not Available[1]	1.3%	3.6%	2.3%	2.7%

Medicare payment

Spending per hospital patient with Medicare (Medicare Spending per Beneficiary)

The "Spending per Hospital Patient with Medicare" (Medicare Spending per Beneficiary) measure shows whether Medicare spends more, less, or about the same on an episode of care for a Medicare patient treated in a specific hospital compared to how much Medicare spends on an episode of care across all hospitals nationally. This measure includes any Medicare Part A and Part B payments made for services provided to a patient during an episode of care, which includes the 3 days prior to the hospital stay, during the stay, and during the 30 days after discharge from the hospital.

This result is a ratio calculated by dividing the amount Medicare spends per patient for an episode of care initiated at this hospital by the median (or middle) amount Medicare spent per episode of care nationally.

A ratio equal to the national average means that Medicare spends ABOUT THE SAME per patient for an episode of care initiated at this hospital as it does per episode of care across all hospitals nationally.

A ratio that is more than the national average means that Medicare spends MORE per patient for an episode of care initiated at this hospital than it does per episode of care across all hospitals nationally.

A ratio that is less than the national average means that Medicare spends LESS per patient for an episode of care initiated at this hospital than it does per episode of care across all hospitals nationally.

Lower ratios means Medicare spends less per patient.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	x BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	x YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	x GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000
Medicare hospital spending per patient (Medicare Spending per Beneficiary)	Get Results for this Hospital	Get Results for this Hospital	Get Results for this Hospital

Number of Medicare patients

Number of Medicare patients treated

This shows the number of Medicare patients with a certain condition (MS-DRG) that a hospital treated during the current data collection period. These data are based on the number of Medicare patients that were discharged with a certain condition. They do not include patients in Medicare health plans.

Select a medical condition or surgical procedure and update your results.

Medical Conditions Surgical Procedures

In the results below, 'CC' refers to complications or comorbidities. 'MCC' refers to major complications or comorbidities.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	x	x	x
	BRIDGEPORT HOSPITAL 267 GRANT STREET BRIDGEPORT, CT 06610 (203) 384-3000	YALE-NEW HAVEN HOSPITAL 20 YORK ST NEW HAVEN, CT 06504 (203) 688-4242	GREENWICH HOSPITAL ASSOCIATION 5 PERRYRIDGE RD GREENWICH, CT 06830 (203) 863-3000

To view Medicare Volume data, select a Medical Condition or Surgical Procedure above and update your results.

In the tables, you can hover over the footnote number to see the footnote text. View more footnote details.

Footnotes

Footnote number	Footnote as displayed on Hospital Compare
1	The number of cases/patients is too few to report.
2	Data submitted were based on a sample of cases/patients.
3	Results are based on a shorter time period than required.
4	Data suppressed by CMS for one or more quarters.
5	Results are not available for this reporting period.
6	Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
7	No cases met the criteria for this measure.
8	The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
9	No data are available from the state/territory for this reporting period.
10	Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
11	There were discrepancies in the data collection process.
12	This measure does not apply to this hospital for this reporting period.
13	Results cannot be calculated for this reporting period.
14	The results for this state are combined with nearby states to protect confidentiality.

Exhibit IX Revised Staffing Attachment I

44a. Staffing Attachment I - FY 2014 Actual

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio			Average Nursing[2] Hours per Patient Day (NHPPD)	Revised	
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight		FY2014 NHPPD Actual[5]	NHPPD Target
01-6074 ICU	ICU	RGH	1:1.60	1:2.00	1:2.00	1:1.75	1:2.30	1:2.30	14.51	14.68	14.00
01-6076 B II	Med/Surg	RGH	1:2.57	1:3.00	1:4.50	1:4.50	1:4.50	1:6.00	8.13	8.09	8.00
01-6144 B II South*	Med/Surg	RGH	1:2.50	1:2.50	1:2.50	1:5.00	1:5.00	1:5.00	8.17	8.37	8.00
01-5060 Emergency Department	ED	RGH	1:1.90	1:1.75	1:1.75	1:2.90	1:2.80	1:3.50	n/a	2.44	2.20
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	10.44	9.85	10.80
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4			
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	15.34	14.69	14.00
80-6165 Adult Inpatient	Psych	MMH	1:3.57	1:3.57	1:6.25	1:6.25	1:6.25	1:12.5	6.14	6.59	7.40
80-6170 Adolescent Inpatient	Psych	MMH	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	1:6.00	8.96	10.05	10.10
80-6220 Second East*	Med/Surg	MMH	1:3.13	1:3.13	1:4.17	1:5.00	1:5.00	1:6.25	8.01	8.07	8.00
80-6225 ICU*	ICU	MMH	1:1.70	1:1.70	1:1.89	1:2.13	1:2.13	1:2.43	14.47	14.35	14.00
80-6230 Special Care Unit*	Med/Surg	MMH	1:2.50	1:3.00	1:3.75	1:3.75	1:3.75	1:50	9.17	9.07	9.00
80-6265 Third North	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30	8.33	8.29	8.00
80-9912 Third West	Med/Surg	MMH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	6.04	2.70	8.00
80-5060 Emergency Department	ED	MMH	1:2.90	1:2.40	1:2.20	1:5.20	1:4.00	1:3.10	n/a	2.13	2.20

Nursing Staff/RN to Patient Ratios: The staff to patient ratios were calculated by dividing the actual average daily census for the unit or department for FY 2014 by the number of nursing staff (or RN) full-time equivalents that would be required to care for patients on the unit given the actual average number of patients present on the unit.

Average Nursing Hours per Patient Day: Calculated by dividing the total number of actual worked hours on a unit or department by the number of patient days for that unit or department in a given fiscal year.
Note "Worked hours" includes regular and overtime hours and does not include other non-productive or non-patient care hours (i.e. training, paid leave, etc.).

Footnotes:
(1) Nursing Staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (NAs) providing direct patient care.
(2) Nursing hours per patient day should include all nursing staff as defined in #1 above.
(3) Mother and baby are counted as one patient in Postpartum area (i.e. 1 nurse to 3 or 4 mother/baby pairs depending on patient acuity)
(4) Number of patients per nursing staff depends on patient acuity.
(5) Prior NHPPD statistic reported were YTD; Revised statistic reflect year-end nursing worked hours per patient day. NHPPD for Emergency Department calculated using ED visit volume.
* Units where the nursing staff/RN to patient ratios have been recalculated based on the actual average daily census experienced in FY 2014.

Exhibit X Supplemental Staffing Attachment

Staffing Attachment I (Exhibit 33) Supplemental Information

Name of Hospital Unit or Department	Patient Days[1]		Average Daily Census		Nursing Staff[3] FTEs		Nursing Staff[3] WHPPD	
	Budget	Actual	Budget	Actual	Budget[6]	Actual	Target	Actual
01-6074 ICU	2,440	2,292	7	6	20.6	16.2	14.00	14.68
01-6076 B II	8,318	8,219	23	23	25.0	32.0	8.00	8.09
01-6144 B II South	2,433	1,506	7	4	12.9	6.1	8.00	8.37
80-5075 Obstetrical Services	5,643	6,319	15	17	35.4	29.9	10.80	9.85
80-5079 NICU	1,300	1,281	4	4	11.1	9.0	14.00	14.69
80-6165 Adult Inpatient[4]	8,458	9,189	23	25	34.2	29.1	7.40	6.59
80-6170 Adolescent Inpatient[4]	1,611	1,699	4	5	8.7	8.2	10.10	10.05
80-6220 Second East	9,828	8,835	27	24	33.2	34.3	8.00	8.07
80-6225 ICU	6,210	5,897	17	16	45.7	40.7	14.00	14.35
80-6230 Special Care Unit	5,890	5,209	16	14	25.3	22.7	9.00	9.07
80-6265 Third North	8,653	8,013	24	22	23.8	32.0	8.00	8.29
80-9912 Third West[5]	378	404	1	1	9.6	0.5	8.00	2.70

Name of Hospital Unit or Department	Visit Volume[2]		Average Daily Visits		Nursing Staff[3] FTEs		Nursing Staff[3] WHPPD	
	Budget	Actual	Budget	Actual	Budget[6]	Actual	Target	Actual
01-5060 Emergency Department	23,365	21,577	64	59	29.4	25.3	2.20	2.44
80-5060 Emergency Department	44,141	41,562	121	114	53.3	42.5	2.20	2.13

Name of Hospital Unit or Department	Patient Days[1]		Average Daily Census		RN FTEs		RN WHPPD	
	Budget	Actual	Budget	Actual	Budget[6]	Actual	Target	Actual
01-6074 ICU	2,440	2,292	7	6	17.4	15.0	11.83	13.63
01-6076 B II	8,318	8,219	23	23	10.4	19.6	3.33	4.95
01-6144 B II South	2,433	1,506	7	4	9.5	3.6	5.89	5.03
80-5075 Obstetrical Services	5,643	6,319	15	17	31.9	26.8	9.73	8.83
80-5079 NICU	1,300	1,281	4	4	11.1	9.0	14.00	14.67
80-6165 Adult Inpatient[4]	8,458	9,189	23	25	17.4	14.5	3.18	3.28
80-6170 Adolescent Inpatient[4]	1,611	1,699	4	5	4.6	4.4	5.80	5.33
80-6220 Second East	9,828	8,835	27	24	19.8	20.9	4.77	4.91
80-6225 ICU	6,210	5,897	17	16	36.3	33.5	11.12	11.81
80-6230 Special Care Unit	5,890	5,209	16	14	16.5	15.3	5.87	6.12
80-6265 Third North	8,653	8,013	24	22	13.9	18.5	4.67	4.80
80-9912 Third West[5]	378	404	1	1	4.8	0.3	4.00	1.49

Name of Hospital Unit or Department	Visit Volume[2]		Average Daily Visits		RN FTEs		RN WHPPD	
	Budget	Actual	Budget	Actual	Budget[6]	Actual	Target	Actual
01-5060 Emergency Department	23,365	21,577	64	59	18.8	15.9	1.4	1.54
80-5060 Emergency Department	44,141	41,562	121	114	31.7	27.9	1.3	1.39

Footnotes:

(1) The Patient Days statistic reflects the number of inpatients, observation patients and same day care patients on each unit each day in FY 2014.

(2) Emergency Department visit volume includes ED non-admissions, ED admissions, ED virtual beds, and observation patients.

(3) Nursing Staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (NAs) providing direct patient care.

(4) Staff provide cross-coverage for adults and adolescents in adjacent units during peak census. Utilization of non-RN staff (i.e. licensed social workers, nursing aids, etc.) has been increased on the adult behavioral health unit in response to increased patient stays and continued growth in demand.

(5) Third West is being used as a med/surg and obstetrics overflow unit. The WHPPD calculation is based on a unit that operates a full 24 hours.
Staff are not assigned to the unit until a patient is admitted. Admitted patients count in full towards the census.
Depending on the timing of admissions, staff may not have been on the unit long enough to have attained the target worked hours per patient day.

(6) Budgeted FTEs included non-productive time and relief hours while the actual FTE statistic reflects only the actual worked hours.

Exhibit XI Financial Attachment I (A) for MMH

Name Entit anchester emorial Hospital Please provide one year of actual results and three years of projections of **otal Entit** revenue, expense and volume statistics
Financial ttachment I without, incremental to and with the CON proposal in the following reporting format:

		1	2	5	6	7	8	9	10	11	12	13
INE	**otal Entit**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**
		ctual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	escription	**esults**	**W/out CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	OPE IN E EN E											
1	Total Gross Patient Revenue	$563,024	$601,360	$610,365	$6,119	$616,484	$619,505	$12,484	$631,989	$628,782	$19,101	$647,883
2	Less: Allowances	$383,297	$421,009	$435,557	$4,367	$439,924	$443,506	$8,937	$452,444	$450,148	$13,675	$463,823
3	Less: Charity Care	$3,909	$2,411	$2,447	$25	$2,472	$2,484	$50	$2,534	$2,521	$77	$2,598
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient er ice e enue	**$175,818**	**$177,940**	**$172,361**	**$1,728**	**$174,089**	**$173,515**	**$3,497**	**$177,011**	**$176,113**	**$5,350**	**$181,463**
5	Medicare	$60,507	$65,814	$61,487	$607	$62,094	$60,980	$1,229	$62,209	$61,894	$1,880	$63,774
6	Medicaid	$26,249	$27,283	$25,631	$259	$25,890	$26,015	$524	$26,539	$26,405	$802	$27,207
7	CHAMPUS & TriCare	$649	$674	$684	$7	$691	$694	$14	$708	$705	$21	$726
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	otal o ernment	**$87,405**	**$93,771**	**$87,802**	**$873**	**$88,675**	**$87,690**	**$1,767**	**$89,457**	**$89,003**	**$2,704**	**$91,707**
9	Commercial Insurers	$85,604	$81,444	$81,792	$827	$82,619	$83,017	$1,673	$84,690	$84,260	$2,560	$86,820
10	Uninsured	$477	$369	$375	$4	$378	$380	$8	$388	$386	$12	$398
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$2,333	$2,357	$2,392	$24	$2,416	$2,428	$49	$2,477	$2,464	$75	$2,539
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	otal Non o ernment	**$88,414**	**$84,170**	**$84,559**	**$855**	**$85,414**	**$85,825**	**$1,729**	**$87,555**	**$87,110**	**$2,646**	**$89,757**
	Net Patient er ice e enue[a] o ernment Non o ernment	**$175,819**	**$177,941**	**$172,361**	**$1,728**	**$174,089**	**$173,515**	**$3,497**	**$177,011**	**$176,113**	**$5,350**	**$181,463**
14	Provision for Bad Debts	$5,518	$3,413	$3,464	$35	**$3,499**	$3,516	$71	**$3,587**	$3,569	$108	**$3,677**
	Net Patient er ice e enue less pro ision or ad de ts	**$170,300**	**$174,527**	**$168,897**	**$1,693**	**$170,590**	**$169,999**	**$3,426**	**$173,425**	**$172,545**	**$5,242**	**$177,786**
15	Other Operating Revenue	$17,830	$14,113	$13,323	($1,655)	**$11,668**	$13,013	($1,655)	**$11,358**	$13,143	($1,655)	**$11,488**
17	Net Assets Released from Restrictions	$1,459	$648	$321	($321)	**$0**	$324	($324)	**$0**	$327	($327)	**$0**
	O OPE IN E EN E	**$189,589**	**$189,288**	**$182,540**	**$282**	**$182,258**	**$183,336**	**$1,447**	**$184,783**	**$186,015**	**$3,260**	**$189,275**
B	**OPE IN E PEN E**											
1	Salaries and Wages	$83,909	$83,085	$79,807	$800	$80,607	$80,994	$1,632	$82,626	$82,199	$2,497	$84,696
2	Fringe Benefits	$27,659	$26,168	$27,273	($5,152)	$22,122	$27,679	($4,918)	$22,761	$28,091	($4,674)	$23,416
3	Physicians Fees	$7,801	$9,280	$9,466	$0	$9,466	$9,655	$0	$9,655	$9,848	$0	$9,848
4	Supplies and Drugs	$24,979	$23,663	$21,993	($423)	$21,570	$22,652	($200)	$22,452	$23,331	$39	$23,371
5	Depreciation and Amortization	$7,115	$7,306	$6,829	$450	$7,278	$6,965	$899	$7,865	$7,105	$1,349	$8,454
6	Provision for Bad Debts-Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$2,685	$2,644	$2,697	($2,413)	$284	$2,751	($2,570)	$181	$2,806	($2,702)	$104
8	Malpractice Insurance Cost	$5,929	$2,932	$2,991	$0	$2,991	$3,050	$0	$3,050	$3,111	$0	$3,111
9	Lease Expense	$2,520	$2,383	$2,431	$0	$2,431	$2,479	$0	$2,479	$2,529	$0	$2,529
10	Other Operating Expenses	$25,738	$26,584	$26,727	$1,213	$27,940	$27,262	$1,187	$28,448	$27,807	$1,159	$28,966
	O OPE IN E PEN E	**$188,335**	**$184,045**	**$180,213**	**$5,524**	**$174,689**	**$183,488**	**$3,970**	**$179,518**	**$186,826**	**$2,331**	**$184,495**
	Provision for Income Taxes[c]	$0	$0	$0	$2,854	**$2,854**	$0	$1,929	**$1,929**	$0	$1,731	**$1,731**
	Earnings Before Interest, Taxes, Depreciation & Amortization **EBI**	**$11,054**	**$15,193**	**$11,853**	**$3,279**	**$15,132**	**$9,564**	**$3,746**	**$13,310**	**$9,099**	**$4,238**	**$13,337**
	INCO E/ O F O OPE ION	**$1,254**	**$5,243**	**$2,328**	**$2,388**	**$4,716**	**$152**	**$3,488**	**$3,336**	**$812**	**$3,860**	**$3,049**

Name Entit anchester emorial Hospital Please provide one year of actual results and three years of projections of **otal Entit** revenue, expense and volume statistics
Financial ttachment I without, incremental to and with the CON proposal in the following reporting format:

		1	2	5	6	7	8	9	10	11	12	13
INE	**otal Entit**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**
		ctual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	escription	**esults**	**W/out CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	NON OPE IN INCO E / E EN E	($1,467)	($1,476)	($435)	$0	($435)	($443)	$0	($443)	($452)	$0	($452)
	NE INCO E / E CE EFICIENCY OF E EN E O E E PEN E	**$213**	**$3,767**	**$1,893**	**$2,388**	**$4,281**	**$595**	**$3,488**	**$2,893**	**$1,264**	**$3,860**	**$2,597**
C	**etained Earnings, eginning o ear**	**$37,945**	**$37,732**	**$41,499**	**$0**	**$41,499**	**$43,392**	**$2,388**	**$45,780**	**$42,797**	**$5,876**	**$48,673**
	etained Earnings, end o ear	**$37,732**	**$41,499**	**$43,392**	**$2,388**	**$45,780**	**$42,797**	**$5,876**	**$48,673**	**$41,533**	**$9,736**	**$51,269**
	Principal Payments	$4,050	$5,142	$6,860	($6,860)	**$0**	$6,368	($6,368)	**$0**	$5,554	($5,554)	**$0**
	P OFI BI I Y Y											
1	Hospital Operating Margin	**0 7**	**2 8**	**1 3**	**846 5**	**2 6**	**0 1**	**241 0**	**1 8**	**0 4**	**118 4**	**1 6**
2	Hospital Non Operating Margin	**0 8**	**0 8**	**0 2**	**0 0**	**0 2**	**0 2**	**0 0**	**0 2**	**0 2**	**0 0**	**0 2**
3	Hospital Total Margin	**0 1**	**2 0**	**1 0**	**846 5**	**2 4**	**0 3**	**241 0**	**1 6**	**0 7**	**118 4**	**1 4**
E	**F Es**	1,099	1,097	1,091	11	**1,102**	1,086	22	**1,108**	1,081	33	**1,113**
F	**O E I IC** [d]											
1	Inpatient Discharges	9,342	9,182	9,136	46	**9,182**	9,090	92	**9,182**	9,045	137	**9,182**
2	Outpatient Visits	364,759	358,809	360,603	1,794	**362,397**	362,406	3,615	**366,021**	364,218	5,463	**369,681**
	O O E	**374,101**	**367,991**	**369,739**	**1,840**	**371,579**	**371,496**	**3,707**	**375,203**	**373,263**	**5,600**	**378,863**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
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 XII Financial Attachment I (A) for RGH

Name Entit oc ille eneral Hospital Please provide one year of actual results and three years of projections of **otal Entit** revenue, expense and volume statistics
Financial ttachment I without, incremental to and with the CON proposal in the following reporting format:

		1	2	5	6	7	8	9	10	11	12	13
INE	**otal Entit**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**
		ctual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	escription	**esults**	**W/out CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	OPE IN E EN E											
1	Total Gross Patient Revenue	$222,665	$227,300	$230,704	$2,313	$233,017	$234,158	$4,719	$238,877	$237,665	$7,220	$244,885
2	Less: Allowances	$148,355	$155,583	$160,522	$1,609	$162,132	$163,509	$3,295	$166,804	$165,957	$5,041	$170,999
3	Less: Charity Care	$1,272	$1,189	$1,207	$12	$1,219	$1,225	$25	$1,250	$1,243	$38	$1,281
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient er ice e enue	**$73,038**	**$70,528**	**$68,975**	**$691**	**$69,666**	**$69,425**	**$1,399**	**$70,824**	**$70,464**	**$2,141**	**$72,605**
5	Medicare	$26,977	$26,434	$25,105	$248	$25,353	$24,899	$502	$25,400	$25,271	$768	$26,039
6	Medicaid	$10,393	$7,377	$6,906	$70	$6,976	$7,009	$141	$7,151	$7,114	$216	$7,330
7	CHAMPUS & TriCare	$254	$295	$299	$3	$302	$304	$6	$310	$308	$9	$318
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	otal o ernment	**$37,624**	**$34,106**	**$32,311**	**$321**	**$32,632**	**$32,212**	**$649**	**$32,861**	**$32,694**	**$993**	**$33,687**
9	Commercial Insurers	$34,074	$34,999	$35,219	$356	$35,575	$35,746	$720	$36,466	$36,281	$1,102	$37,383
10	Uninsured	$177	$204	$207	$2	$209	$210	$4	$214	$213	$6	$220
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$1,163	$1,220	$1,238	$13	$1,251	$1,257	$25	$1,282	$1,276	$39	$1,314
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	otal Non o ernment	**$35,414**	**$36,423**	**$36,664**	**$371**	**$37,035**	**$37,213**	**$750**	**$37,963**	**$37,770**	**$1,147**	**$38,918**
	Net Patient er ice e enue[a] o ernment Non o ernment	**$73,038**	**$70,529**	**$68,975**	**$691**	**$69,666**	**$69,425**	**$1,399**	**$70,824**	**$70,464**	**$2,141**	**$72,605**
14	Provision for Bad Debts	$4,127	$1,415	$1,436	$14	**$1,451**	$1,458	$29	**$1,487**	$1,480	$45	**$1,524**
	Net Patient er ice e enue less pro ision or ad de ts	**$68,911**	**$69,113**	**$67,538**	**$677**	**$68,216**	**$67,967**	**$1,370**	**$69,337**	**$68,985**	**$2,096**	**$71,081**
15	Other Operating Revenue	$5,965	$3,590	$3,104	($403)	**$2,701**	$2,692	($403)	**$2,290**	$2,719	($403)	**$2,316**
17	Net Assets Released from Restrictions	$113	$113	$64	($64)	**$0**	$64	($64)	**$0**	$65	($65)	**$0**
	O OPE IN E EN E	**$74,989**	**$72,816**	**$70,706**	**$211**	**$70,916**	**$70,724**	**$903**	**$71,626**	**$71,769**	**$1,628**	**$73,397**
B	**OPE IN E PEN E**											
1	Salaries and Wages	$31,510	$32,131	$31,673	$318	$31,991	$32,144	$648	$32,792	$32,622	$991	$33,613
2	Fringe Benefits	$10,025	$9,767	$9,998	($1,615)	$8,383	$10,146	($1,530)	$8,617	$10,297	($1,441)	$8,857
3	Physicians Fees	$2,943	$3,443	$3,512	$0	$3,512	$3,582	$0	$3,582	$3,654	$0	$3,654
4	Supplies and Drugs	$10,014	$9,529	$8,663	($232)	$8,431	$8,923	($146)	$8,777	$9,190	($53)	$9,137
5	Depreciation and Amortization	$3,565	$3,461	$3,344	$173	$3,517	$3,411	$346	$3,757	$3,479	$519	$3,998
6	Provision for Bad Debts-Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$682	$685	$699	($686)	$13	$713	($708)	$5	$727	($726)	$1
8	Malpractice Insurance Cost	$2,171	$977	$997	$0	$997	$1,016	$0	$1,016	$1,037	$0	$1,037
9	Lease Expense	$969	$1,042	$1,063	$0	$1,063	$1,084	$0	$1,084	$1,106	$0	$1,106
10	Other Operating Expenses	$9,791	$11,161	$10,637	$395	$11,031	$10,849	$384	$11,234	$11,066	$374	$11,440
	O OPE IN E PEN E	**$71,670**	**$72,196**	**$70,584**	**$1,648**	**$68,936**	**$71,868**	**$1,005**	**$70,863**	**$73,178**	**$336**	**$72,842**
	Provision for Income Taxes[c]	$0	$0	$0	$871	**$871**	$0	$386	**$386**	$0	$304	**$304**
	Earnings Before Interest, Taxes, Depreciation & Amortization **EBI**	**$7,566**	**$4,766**	**$4,164**	**$1,346**	**$5,510**	**$2,979**	**$1,546**	**$4,524**	**$2,797**	**$1,756**	**$4,553**
	INCO E/ O F O OPE ION	**$3,319**	**$620**	**$122**	**$987**	**$1,109**	**$1,145**	**$1,522**	**$378**	**$1,409**	**$1,660**	**$251**

Name Entit oc ille eneral Hospital
Financial ttachment I

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

		1	2	5	6	7	8	9	10	11	12	13
INE	**otal Entit**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**
		ctual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	escription	**esults**	**W/out CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	NON OPE IN INCO E / E EN E	($660)	($227)	$197	$0	$197	$201	$0	$201	$205	$0	$205
	NE INCO E / E CE EFICIENCY OF E EN E O E E PEN E	**$2,659**	**$393**	**$319**	**$987**	**$1,306**	**$944**	**$1,522**	**$578**	**$1,204**	**$1,660**	**$456**
C	**etained Earnings, eginning o ear**	**$28,393**	**$31,052**	**$31,445**	**$0**	**$31,445**	**$31,764**	**$987**	**$32,752**	**$30,821**	**$2,509**	**$33,330**
	etained Earnings, end o ear	**$31,052**	**$31,445**	**$31,764**	**$987**	**$32,752**	**$30,821**	**$2,509**	**$33,330**	**$29,617**	**$4,169**	**$33,786**
	Principal Payments	$1,276	$874	$6,860	($6,860)	**$0**	$6,368	($6,368)	**$0**	$5,554	($5,554)	**$0**
	P OFI BI I Y Y											
1	Hospital Operating Margin	**4 5**	**0 9**	**0 2**	**468 8**	**1 6**	**1 6**	**168 6**	**0 5**	**2 0**	**102 0**	**0 3**
2	Hospital Non Operating Margin	**0 9**	**0 3**	**0 3**	**0 0**	**0 3**	**0 3**	**0 0**	**0 3**	**0 3**	**0 0**	**0 3**
3	Hospital Total Margin	**3 6**	**0 5**	**0 4**	**468 8**	**1 8**	**1 3**	**168 6**	**0 8**	**1 7**	**102 0**	**0 6**
E	**F Es**	382	378	376	4	**380**	374	8	**382**	372	11	**384**
F	**O E I IC** [d]											
1	Inpatient Discharges	2,567	2,371	2,359	12	**2,371**	2,347	24	**2,371**	2,336	35	**2,371**
2	Outpatient Visits	95,911	92,183	92,644	461	**93,105**	93,107	929	**94,036**	93,573	1,404	**94,976**
	O O E	**98,478**	**94,554**	**95,003**	**473**	**95,476**	**95,454**	**952**	**96,407**	**95,908**	**1,439**	**97,347**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
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 XIII Financial Attachment I (A) for MMH & RGH Assumptions

MMH FINANCIAL ASSUMPTIONS

Projected without CON

1. Main drivers that apply to each year:
    a. 0.5% decline in discharges each year;
    b. 0.5% increase in outpatient visits each year;
    c. 0.5% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions.
    e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    f. Net patient revenue per adjusted discharge increase of 1.5% each year
    g. Bad debt expense remains consistent at 2.0% of net patient service revenues
    h. Increase of 3% in supplies and drugs pricing each year
    i. Inflation 2% each year
    j. Increase of 1% for other operating revenues each year

2. Other Factors/Assumptions/Adjustments for FY 2015
    a. $3.4 million cut in Medicare due to wage index
    b. $2.0 million cut in Medicaid payments
    c. $2.8 million increase in pension expense
    d. $0.8 million increase in defined contribution plan funding
    e. $1.7 million decline in outpatient revenues
    f. $2.9 million reduction in labor costs to offset above reimbursement cuts
    g. $2.3 million reduction in benefits related to restructured plan designs
    h. $2.6 million reduction to supply chain and purchasing efficiencies
    i. Bad debt expense remains consistent at 2.0% of net patient service revenues
    j. Other operating revenues declining due to reductions in meaningful use incentives and realized gains
    k. Non-operating expenses are reduced to exclude non-recurring items
    l. Medicare reimbursement reduced due to one-time adjustment in FY 14
    m. Other one-time FY 14 adjustments eliminated; inventory, settlements, etc.

3. Other Factors/Assumptions/Adjustments for FY 2016
    a. $1.4 million cut in Medicare due to wage index
    b. Other operating revenues declining further due to reductions in meaningful use incentives

Projected with CON

1. Main drivers that apply to each year:
    a. Discharge volume is unchanged in each projected year;
    b. 1.0% increase in outpatient visits each year;
    c. 1.0% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions;
    e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    f. Net patient revenue per adjusted discharge increase of 1.5% each year;
    g. Bad debt expense remains consistent at 2.0% of net patient service revenues;
    h. Increase of 3% in supplies and drugs pricing each year;
    i. Inflation 2% each year; and
    j. Increase of 1% for other operating revenues each year.

2. Adjustments to financials resulting from CON
    a. Incremental volume drives the incremental revenue. Incremental expense associated with incremental volume is coupled with the assumptions below;
    b. Estimated sales and property tax are layered into the projected years;
    c. Supply expense is reduced by $1.7 million related to increased purchasing power from affiliating with Tenet;
    d. Other operating revenue is reduced by $1.7 million related to the absence of investment income and charitable contributions. Note that these sources of revenue would continue to be available to the community foundation established by ECHN;
    e. Other operating expenses are reduced by approximately $1.3 million reductions in purchased services;
    f. Fringe benefits expense is reduced by approximately $2.5 million as Tenet will provide a benefit plan more cost effectively as a result of greater purchasing power;
    g. Pension expenses are deducted from Fringe Benefits;
    h. Depreciation and Amortization expense is based upon a blended useful life of 14 years;
    i. Interest expense is reduced as the standalone entity will not be levered. The remaining interest expense is related to capital leases; and
    j. Income tax layered into the expense structure assuming a 40% income tax rate.

RGH FINANCIAL ASSUMPTIONS

Projected without CON

1. Main drivers that apply to each year:
    a. 0.5% decline in discharges each year;
    b. 0.5% increase in outpatient visits each year;
    c. 0.5% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions.
    e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    f. Net patient revenue per adjusted discharge increase of 1.5% each year
    g. Bad debt expense remains consistent at 2.1% of net patient service revenues
    h. Increase of 3% in supplies and drugs pricing each year
    i. Inflation 2% each year
    j. Increase of 1% for other operating revenues each year

2. Other Factors/Assumptions/Adjustments for FY 2015
    a. $1.4 million cut in Medicare due to wage index
    b. $0.6 million cut in Medicaid payments
    c. $0.7 million increase in pension expense
    d. $0.2 million increase in defined contribution plan funding
    e. $0.6 million decline in outpatient revenues
    f. $0.3 million reduction in labor costs to offset above reimbursement cuts
    g. $0.7 million reduction in benefits related to restructured plan designs
    h. $1.1 million reduction to supply chain and purchasing efficiencies
    i. Bad debt expense remains consistent at 2.1% of net patient service revenues
    j. Other operating revenues declining due to reductions in meaningful use incentives and realized gains
    k. Non-operating expenses are reduced to exclude non-recurring items
    l. Other one-time FY 14 adjustments eliminated; inventory, settlements, etc.

3. Other Factors/Assumptions/Adjustments for FY 2016
    a. $0.6 million cut in Medicare due to wage index
    b. Other operating revenues declining further due to reductions in meaningful use incentives

Projected with CON

1. Main drivers that apply to each year:
    a. Discharge volume is unchanged in each projected year;
    b. 1.0% increase in outpatient visits each year;
    c. 1.0% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions;
    e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    f. Net patient revenue per adjusted discharge increase of 1.5% each year;
    g. Bad debt expense remains consistent at 2.1% of net patient service revenues;
    h. Increase of 3% in supplies and drugs pricing each year;
    i. Inflation 2% each year; and
    j. Increase of 1% for other operating revenues each year.

2. Adjustments to financials resulting from CON
    a. Incremental volume drives the incremental revenue. Incremental expense associated with incremental volume is coupled with the assumptions below;
    b. Estimated sales and property tax are layered into the projected years;
    c. Supply expense is reduced by $0.7 million related to increased purchasing power from affiliating with Tenet;
    d. Other operating revenue is reduced by $0.4 million related to the absence of investment income and charitable contributions. Note that these sources of revenue would continue to be available to the community foundation established by ECHN;
    e. Other operating expenses are reduced by approximately $0.5 million reductions in purchased services;
    f. Fringe benefits expense is reduced by approximately $1.0 million as Tenet will provide a benefit plan more cost effectively as a result of greater purchasing power;
    g. Pension expenses are deducted from Fringe Benefits;
    h. Depreciation and Amortization expense is based upon a blended useful life of 14 years;
    i. Interest expense is reduced as the standalone entity will not be levered. The remaining interest expense is related to capital leases; and
    j. Income tax layered into the expense structure assuming a 40% income tax rate.

Exhibit XIV Revised Financial Attachment I (A) for ECHN

Name Entit H Eastern C
Financial ttachment I

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

INE	otal Entit escription	1 FY 2013 ctual esults	2 FY 2014 Projected W/out CON	5 FY 2015 Projected W/out CON	6 FY 2015 Projected Incremental	7 FY 2015 Projected With CON	8 FY 2016 Projected W/out CON	9 FY 2016 Projected Incremental	10 FY 2016 Projected With CON	11 FY 2017 Projected W/out CON	12 FY 2017 Projected Incremental	13 FY 2017 Projected With CON
	OPE IN E EN E											
1	Total Gross Patient Revenue	$891,126	$926,885	$940,765	$18,964	$959,729	$954,852	$29,014	$983,866	$969,151	$39,460	$1,008,611
2	Less: Allowances	$575,823	$609,883	$630,565	$12,711	$643,276	$642,017	$19,508	$661,526	$651,631	$26,532	$678,163
3	Less: Charity Care	$5,181	$3,599	$3,653	$74	$3,727	$3,708	$113	$3,820	$3,763	$153	$3,916
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient er ice e enue	**$310,122**	**$313,403**	**$306,547**	**$6,180**	**$312,726**	**$309,127**	**$9,393**	**$318,521**	**$313,757**	**$12,775**	**$326,531**
5	Medicare	$116,385	$120,171	$114,587	$2,285	$116,871	$114,293	$3,473	$117,766	$116,004	$4,723	$120,728
6	Medicaid	$48,499	$47,955	$46,031	$934	$46,965	$46,720	$1,420	$48,140	$47,420	$1,931	$49,351
7	CHAMPUS & TriCare	$902	$968	$982	$20	$1,002	$997	$30	$1,028	$1,012	$41	$1,053
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	otal o ernment	**$165,786**	**$169,094**	**$161,600**	**$3,239**	**$164,839**	**$162,010**	**$4,923**	**$166,933**	**$164,436**	**$6,695**	**$171,132**
9	Commercial Insurers	$137,819	$137,147	$137,678	$2,793	$140,472	$139,740	$4,246	$143,986	$141,832	$5,775	$147,607
10	Uninsured	$654	$573	$582	$12	$593	$590	$18	$608	$599	$24	$624
11	Self Pay	$2,284	$2,934	$2,978	$60	$3,038	$3,023	$92	$3,114	$3,068	$125	$3,193
12	Workers Compensation	$3,579	$3,654	$3,709	$75	$3,784	$3,764	$114	$3,879	$3,821	$156	$3,976
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	otal Non o ernment	**$144,336**	**$144,308**	**$144,946**	**$2,941**	**$147,887**	**$147,117**	**$4,470**	**$151,587**	**$149,320**	**$6,080**	**$155,400**
	Net Patient er ice e enue[a] o ernment Non o ernment	**$310,122**	**$313,402**	**$306,547**	**$6,180**	**$312,726**	**$309,127**	**$9,393**	**$318,521**	**$313,757**	**$12,775**	**$326,531**
14	Provision for Bad Debts	$11,142	$11,365	$11,535	$233	**$11,768**	$11,708	$356	**$12,064**	$11,883	$484	**$12,367**
	Net Patient er ice e enue less pro ision or ad de ts	**$298,980**	**$302,038**	**$295,012**	**$5,947**	**$300,958**	**$297,420**	**$9,037**	**$306,457**	**$301,873**	**$12,291**	**$314,164**
15	Other Operating Revenue	$27,116	$27,695	$26,519	($2,735)	**$23,784**	$25,898	($2,735)	**$23,163**	$26,157	($2,735)	**$23,422**
17	Net Assets Released from Restrictions	$1,871	$972	$505	($505)	**$0**	$510	($510)	**$0**	$515	($515)	**$0**
	O OPE IN E EN E	**$327,967**	**$330,705**	**$322,035**	**$2,707**	**$324,742**	**$323,828**	**$5,792**	**$329,620**	**$328,545**	**$9,041**	**$337,586**
B	**OPE IN E PEN E**											
1	Salaries and Wages	$163,729	$165,275	$161,287	$3,251	$164,538	$163,686	$4,974	$168,660	$166,121	$6,764	$172,885
2	Fringe Benefits	$47,592	$46,334	$47,235	($7,148)	$40,087	$47,938	($6,733)	$41,204	$48,651	($6,301)	$42,350
3	Physicians Fees	$3,158	$5,128	$5,231	$0	$5,231	$5,335	$0	$5,335	$5,442	$0	$5,442
4	Supplies and Drugs	$36,357	$37,557	$35,394	($529)	$34,865	$36,455	($159)	$36,296	$37,548	$236	$37,784
5	Depreciation and Amortization	$12,291	$12,143	$12,014	$786	$12,800	$11,877	$1,571	$13,448	$11,472	$2,357	$13,829
6	Provision for Bad Debts-Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,908	$3,801	$3,877	($3,580)	$297	$3,955	($3,769)	$185	$4,034	($3,929)	$104
8	Malpractice Insurance Cost	$8,373	$5,621	$5,733	$0	$5,733	$5,848	$0	$5,848	$5,965	$0	$5,965
9	Lease Expense	$6,265	$6,607	$6,739	$0	$6,739	$6,874	$0	$6,874	$7,011	$0	$7,011
10	Other Operating Expenses	$46,182	$48,109	$47,472	$1,911	$49,383	$48,421	$1,865	$50,286	$49,390	$1,817	$51,207
	O OPE IN E PEN E	**$327,855**	**$330,575**	**$324,982**	**$5,308**	**$319,674**	**$330,389**	**$2,252**	**$328,137**	**$335,633**	**$944**	**$336,577**
	Provision for Income Taxes[c]	$0	$0	$0	$1,881	**$1,881**	$0	$444	**$444**	$0	$252	**$252**
	Earnings Before Interest, Taxes, Depreciation & Amortization **EBI**	**$16,311**	**$16,074**	**$12,944**	**$5,221**	**$18,165**	**$9,270**	**$5,846**	**$15,117**	**$8,418**	**$6,524**	**$14,942**
	INCO E/ O F O OPE ION	**$112**	**$130**	**$2,947**	**$6,134**	**$3,187**	**$6,561**	**$7,600**	**$1,039**	**$7,088**	**$7,845**	**$757**

Name Entit H Eastern C
Financial ttachment I

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

		1	2	5	6	7	8	9	10	11	12	13
INE	**otal Entit**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**
		ctual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	escription	**esults**	**W/out CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
	NON OPE IN INCO E / E EN E	($2,139)	($1,858)	($365)	$0	($365)	($372)	$0	($372)	($380)	$0	($380)
	NE INCO E / E CE EFICIENCY OF E EN E O E E PEN E	**$2,027**	**$1,728**	**$3,312**	**$6,134**	**$2,822**	**$6,934**	**$7,600**	**$666**	**$7,468**	**$7,845**	**$377**
C	**etained Earnings, eginning o ear**	$87,876	$85,849	**$84,121**	**$0**	**$84,121**	**$80,809**	**$6,134**	**$86,943**	**$73,875**	**$13,734**	**$87,609**
	etained Earnings, end o ear	$85,849	$84,121	**$80,809**	**$6,134**	**$86,943**	**$73,875**	**$13,734**	**$87,609**	**$66,407**	**$21,579**	**$87,986**
	Principal Payments	$7,079	$8,224	$6,860	($6,860)	**$0**	$6,368	($6,368)	**$0**	$5,554	($5,554)	**$0**
	P OFI BI I Y Y											
1	Hospital Operating Margin	**0 0**	**0 0**	**0 9**	**226 6**	**1 0**	**2 0**	**131 2**	**0 3**	**2 2**	**86 8**	**0 2**
2	Hospital Non Operating Margin	**0 7**	**0 6**	**0 1**	**0 0**	**0 1**	**0 1**	**0 0**	**0 1**	**0 1**	**0 0**	**0 1**
3	Hospital Total Margin	**0 6**	**0 5**	**1 0**	**226 6**	**0 9**	**2 1**	**131 2**	**0 2**	**2 3**	**86 8**	**0 1**
E	**F Es**	**2,320**	2,297	2,242	45	**2,287**	2,230	68	**2,298**	2,219	90	**2,309**
F	**O E I IC** [d]											
1	Inpatient Discharges	11,909	11,451	11,394	57	**11,451**	11,337	114	**11,451**	11,280	171	**11,451**
2	Outpatient Visits	460,670	450,992	453,247	2,255	**455,502**	455,513	4,544	**460,057**	457,791	6,867	**464,658**
	O O E	**472,579**	**462,443**	**464,641**	**2,312**	**466,953**	**466,850**	**4,658**	**471,508**	**469,071**	**7,038**	**476,109**

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

Projected without CON

1. Main drivers that apply to each year:
    a. 0.5% decline in discharges each year
    b. 0.5% increase in adjustment factor each year
    c. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions
    d. Employee productivity is expected to improve by 0.5% each year
    e. Net patient revenue per adjusted discharge increase of 1.5% each year
    f. Bad debt expense remains consistent at 3.8% of net patient service revenues
    g. Increase of 3% in supplies and drugs pricing each year
    h. Inflation 2% each year
    i. Increase of 1% for other operating revenues each year

2. Other Factors/Assumptions/Adjustments for FY 2015
    a. $4.8 million cut in Medicare due to wage index
    b. $2.6 million cut in Medicaid payments
    c. $3.5 million increase in pension expense
    d. $1.0 million increase in defined contribution plan funding
    e. $3.0 million decline in outpatient revenues
    f. $3.5 million reduction in labor costs to offset above reimbursement cuts
    g. $3.4 million reduction in benefits to related to a restructured plan designs
    h. $3.7 million related to supply chain and purchasing efficiencies
    i. Bad debt expense remains consistent at 3.8% of net patient service revenues
    j. Other operating revenues declining due to reductions in meaningful use incentives and realized gains
    k. Non-operating expenses are reduced to exclude non-recurring items
    l. Medicare reimbursement reduced due to one-time adjustment in FY 14
    m. Other one-time FY 14 adjustments eliminated; inventory, settlements, etc.

3. Other Factors/Assumptions/Adjustments for FY 2016
    a. $2.0 million cut in Medicare due to wage index
    b. Other operating revenues declining further due to reductions in meaningful use incentives

Projected with CON

1. Main drivers that apply to each year:
    a. Discharge volume is unchanged in each projected year;
    b. 1.0% increase in adjustment factor each year;

c. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions
d. Employee productivity is expected to improve by 0.5% each year;
e. Net patient revenue per adjusted discharge increase of 1.5% each year;
f. Bad Debt Expense remains consistent at 3.8% of net patient service revenues;
g. Increase of 3% in supplies and drugs pricing each year;
h. Inflation 2% each year; and
i. Increase of 1% for other operating revenues each year.

2. Adjustments to financials resulting from CON
    a. Incremental volume drives the incremental revenue. Incremental expense associated with the incremental volume is coupled with the assumptions below;
    b. Estimated sales and property taxes are layered into the projected years;
    c. Supply expense is reduced by $2.6 million related increased purchasing power from affiliating with Tenet;
    d. Other operating revenue is reduced by $2.7 million related to the absence of investment income and charitable contributions. Note that these sources of revenues would continue to be available to the community foundation established by ECHN;
    e. Other operating expenses are reduced by approximately $2.3 million reductions in purchased services;
    f. Fringe benefits expense is reduced by approximately $4.5 million as Tenet will provide a benefit plan more cost effectively as a result of greater purchasing power;
    g. Pension expenses are deducted from Fringe Benefits;
    h. Depreciation and Amortization expense is based upon a blended useful life of 14 years;
    i. Interest expense is reduced as the standalone entity will not be levered. The remaining interest expense is related to capital leases; and
    j. Income tax layered into the expense structure assuming a 40% income tax rate.

Exhibit XV Schedule H, Part II, Community Building Activities – Activity Detail and Spending Allocated to Each Entity

Schedule H, Part II, Community Building Activities - Activity Detail and Spending Allocated to Each Activity

	Activity Detail for FY 2013 (as reported on the 2012 Schedule H)	Manchester Memorial Hospital	Rockville General Hospital
1	Physical improvements and housing	-	-
2	Economic development	946	915
	Tolland Chamber Board Participation	*861*	-
	Glastonbury Chamber Wellness Council Participation	*85*	-
3	Community support	1,390,450	-
	Veteran's Day Ceremony, Veterans Dinner, Food Drive, etc.	*4,138*	*847*
	Family Development Center Programs	*1,385,979*	-
	Speaking engagements to Manchester Community Services Council and South Windsor Chamber (Topics: Impact of Health Care Reform, Medicare Changes and the Impact on Community Hospitals)	*333*	*68*
4	Environmental improvements	-	-
5	Leadership development and training for community members	-	-
6	Coalition building	16,615	112
	Various levels of participation (representing Adolescent Behavioral Health) on the following boards/committees: **East of the River System of Care** (collaborative effort to coordinate adolescent behavioral health services to prevent system gaps that would prevent a child from obtaining the behavioral health services they need) **Vernon Public Schools** (meetings to examine what behavioral health services were available to the Vernon Public Schools either in their school in in collaboration with school services) **Vernon Community Network** (community workgroup that included Vernon social services and provided care to individuals of all ages) **System of Care** (Initiative to coordinate care of adolescents with extremely complex needs - objective was to facilitate dialogue between agencies to develop a community based plan that would support the patient) **Vernon Youth Meeting** (opportunity to share information on community-based behavioral health resources to support adolescents and their families with issues) **East Central Multidisciplinary Team** (Collaborative effort connecting law enforcement, mental health, medical, and DCF investigation processes intended to cause less harm to victims and minimizing re-victimization by having to go through their tragedy multiple times with these various entities) **Manchester Truancy Board** (participation on the now called Student Attendance Review Board - Collaboration with DCF, Juvenile Probation, Police, Mental Health, Local Agencies, Board of Education to address and offer various options for high-risk kids that are missing school) **Vernon Juvenile Review Board** (Diversion program to keep children and adolescents with low level arrests or citations who are referred to the Board out of the legal system) **Vernon Student Attendance Review Board** (collaboration with DCF, Juvenile Probation, Police, Mental Health, Local Agencies, Board of Education to address and offer various options for high-risk kids that are missing school)	*5,520*	-
	Community group participation (representing Oncology Services): *Vernon Community Network*	*64*	-
	Community group participation (representing Emergency Services): *First Choice Health Centers, Inc. (Board Member and attendance at Performance Improvement meetings)*	*5,353*	-

Schedule H, Part II, Community Building Activities - Activity Detail and Spending Allocated to Each Activity

	Activity Detail for FY 2013 (as reported on the 2012 Schedule H)	**Manchester Memorial Hospital**	**Rockville General Hospital**
	Community group participation (representing MMH Trauma Center) on the following boards/committees: *Regional ED Standards* *Regional Medical Advisory Committee* *Regional MAC* *CT EMS Advisory Board* *EMS Clinical Coordinators* *CT EMS Education & Training* *Tolland Windham Mutual Aid* *Manchester Road Race EMS*	*4,501*	*-*
	General community networking to increase awareness of child and adolescent behavioral health services available to the community	*-*	*74*
	10 Steps to Successful Breast Feeding Collaborative	*1,083*	*-*
	Family Development Center Advisory Meeting Participation	*94*	*38*
7	Community health improvement advocacy	4,891	1,704
	Hospital Day at the Capital preparation and participation	*1,766*	*361*
	American Hospital Association Regional Policy Board participation	*3,125*	*1,343*
8	Workforce development	337,699	170
	Work training (helps patients find work in community following mental health episodes)	*329,276*	*-*
	Presentation to Vernon Middle School *(Topic: Career opportunities in healthcare and oncology services*	*192*	*-*
	Presentation to Vernon Middle School *(Topic: Career opportunities in healthcare and rehabilitation services)*	*-*	*170*
	Career Advancement Program (shadowing opportunities in the MMH ED for Manchester High School seniors interested in pursuing a career in healthcare)	*8,231*	*-*
9	Other	-	-
10	Total	1,750,601	2,901

Exhibit XVI Monthly Financial Statistics reports for the months of September and October FY 2014, current month and year-to-date, and comparable period for FY 2013, for each of MMH and RGH only, ECHN, and YNHHS

	Rockville General Hospital				Manchester Memorial Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	Sep-14	Sep-13	Sep-14	Sep-13	Sep-14	Sep-13	Sep-14	Sep-13	Sep-14	Sep-13	Sep-14	Sep-13
A. Operating Performance												
Operating Margin	0.36%	-12.02%	0.85%	4.47%	4.41%	0.39%	2.79%	0.67%	7.22%	-0.80%	0.04%	0.03%
Non-Operating Margin	0.95%	-4.86%	-0.31%	-0.89%	-0.17%	-1.16%	-0.79%	-0.78%	-1.48%	-2.70%	-0.57%	-0.66%
Total Margin	1.31%	-16.88%	0.54%	3.58%	4.24%	-0.76%	2.01%	-0.11%	5.74%	-3.50%	-0.53%	-0.62%
Bad Debt as % of Gross Revenue	0.29%	1.35%	0.48%	1.85%	0.54%	0.65%	0.45%	0.98%	0.91%	0.52%	0.60%	1.25%
B. Liquidity												
Current Ratio	1.59	1.31	1.59	1.31	1.18	1.19	1.18	1.19	1.38	1.31	1.38	1.31
Days Cash on Hand	76	68	78	75	42	47	42	51	84	73	75	79
Days in Net Accounts Receivable	54	60	52	54	53	69	52	71	65	66	52	64
Average Payment Period	48	51	49	57	80	75	80	84	73	71	68	74
C. Leverage and Capital Structure												
Long-term Debt to Equity	0.84	0.76	0.84	0.76	2.1	1.3	2.1	1.3	1.07	0.98	1.07	0.98
Long-term Debt to Capitalization	0.46	0.43	0.46	0.43	0.68	0.57	0.68	0.57	0.52	0.50	0.52	0.50
Unrestricted Cash to Debt	0.63	0.60	0.63	0.60	0.40	0.50	0.40	0.50	0.82	0.81	0.80	0.81
Times Interest Earned Ratio	5.94	(15.18)	6.33	10.12	7.24	0.66	5.20	3.57	11.0	(1.6)	3.8	3.6
Debt Service Coverage Ratio	2.60	(9.65)	2.80	3.53	2.74	0.23	2.00	1.43	3.36	(0.48)	1.30	1.28
Equity Financing Ratio	0.37	0.41	0.37	0.41	0.15	0.22	0.15	0.22	0.28	0.30	0.28	0.30
D. Additional Statistics												
Income from Operations	$ 22,000	$ (645,825)	$ 620,000	$ 3,318,846	$ 696,000	$ 66,059	$ 5,243,000	$ 1,254,009	$1,927,986	($221,260)	$130,000	$112,495
Revenue Over/(Under) Expense	$ 80,000	$ (906,887)	$ 393,000	$ 2,658,611	$ 669,000	$ (127,998)	$ 3,767,000	$ (212,690)	$1,533,306	($964,205)	($1,728,000)	($2,026,094)
EBITDA	$ 279,819	$ (523,451)	$ 4,590,896	$ 7,566,173	$ 1,448,804	$ 316,107	$ 14,949,106	$ 11,054,356	$3,119,602	$314,780	$16,091,365	$16,303,800
Patient Cash Collected	$ 5,768,359	$ 5,607,565	$ 69,882,925	$ 71,237,625	$ 14,901,325	$ 13,603,024	175,898,861	$ 167,083,624	$ 25,281,862	$ 24,166,865	$ 303,167,311	$ 296,869,037
Cash and Cash Equivalents	$ 14,804,423	$ 14,042,731	$ 14,804,423	$ 14,042,731	$ 20,196,052	$ 25,201,350	$ 20,196,052	$ 25,201,350	$67,638,627	$68,587,027	$65,852,216	$68,587,027
Net Working Capital	$ 5,447,981	$ 3,318,194	$ 5,447,981	$ 3,318,194	$ 6,869,776	$ 7,820,200	$ 6,869,776	$ 7,820,200	$ 22,266,595	$ 20,044,190	$ 22,266,595	$ 20,044,190
Unrestricted Assets	$ 23,746,961	$ 26,773,989	$ 23,746,961	$ 26,773,989	$ 10,166,157	$ 27,759,932	$ 10,166,157	$ 27,759,932	$ 58,981,727	$ 70,965,928	$ 58,981,727	$ 70,965,928
Credit Ratings (Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Yale New Have Health System
($ in thousands)

	For the month Ending September 30, 2014	For the year Ending September 30, 2014
A. Operating Performance		
Operating Margin	12.2%	5.5%
Non-Operating Margin	-5.2%	0.8%
Total Margin	7.1%	6.4%
Bad Debt as % Gross Revenue	*	*
B. Liquidity		
Current Ratio	3.01	3.01
Days Cash on Hand	184	184
Days in Net Accounts Receivables**	YNHH - 40.2	YNHH - 40.2
	BH - 41.4	BH - 41.4
	GH - 42.0	GH - 42.0
Average Payment Period	56.8	56.8
C. Leverage and Capital Structure		
Long-term Debt to Equity	53.8%	53.8%
Long-term Debt to Capitalization	37.9%	37.9%
Unrestricted Cash to Debt	1.51	1.51
Times Interest Earned Ratio	9.04	9.04
Debt Service Coverage Ratio	*	*
Equity Financing Ratio	44.5%	44.5%
D. Additional Statistics		
Income from Operating	37,946	188,802
Revenue Over/(under) Expense	21,969	216,489
EBITDA	47,056	436,018
Patient Cash Collected	274,805	3,165,591
Cash and Cash Equivalents	161,026	161,026
Net Working Capital	1,118,699	1,118,699
Unrestricted Assets	1,656,830	1,656,830
Credit Ratings (S&P, FITCH, and Moody's)	see below	see below

* Information not yet available; information needed from external parties
** Days in AR not calculated for System

S&P, FITCH, and Moody's	Fitch	Fitch	Moody's	S&P
Bridgeport Hospital	AA-	AA-	Aa3	not rated
Greenwich Hospital	AA-	AA-	not rated	A+
YNHHS OG	AA-	AA-	Aa3	A+