EXHIBIT Q3-1

LETTER OF INTENT, AS AMENDED

10780 Santa Monica Blvd
Suite 400
Los Angeles, CA 90025
Tel (310) 943-4500
Fax (310) 943-4501

April 30, 2015

Via E-Mail

Mr. Carl Contadini, Chairman
Greater Waterbury Health Network
64 Robbins Street
Waterbury, CT 06708

Re: Greater Waterbury Health Network

Dear Mr. Contadini:

Please accept this Letter of Intent related to a transaction in which Prospect Medical Holdings, Inc. ("Prospect") or a designated subsidiary, would acquire the assets of Greater Waterbury Health Network (collectively "GWHN").

Our interest in GWHN is based on its location in a very attractive market, its strong presence and commitment to its local community, its reputation for quality and service, and its significant potential for growth. We believe that this is the right opportunity for Prospect and plan to build upon GWHN's significant achievements as an essential community system in the greater Waterbury service area. We plan to implement our operating model (which we call a Coordinated Regional Care ("CRC")) by developing a healthcare delivery network encompassing the entire continuum of patient care including home health, clinics, independent physicians, nursing homes, ambulatory surgical centers, out-patient diagnostic services and other health care related services.

Furthermore, we plan to establish a strong physician network by recruiting additional high quality physicians to GWHN's medical staff and implementing a robust physician engagement model which when fully developed, will allow GWHN to further establish its position as the provider of choice in its current service areas and beyond. It is our vision and mission to build on a quality driven, cost-effective healthcare delivery network in the communities served by GWHN and to support the teaching programs at GWHN.

Please note that Prospect has already engaged Mr. Patrick McCabe of Capitol Strategies Group to assist us with respect to regulatory consents and approvals. We have reviewed the conditions of approval promulgated by both the Attorney General's office as well as Office of Health Care

Access relative to the Tenet transaction. We are already in the process of setting up meetings with the appropriate agencies, regulatory authorities and others regarding potential transactions in Connecticut. Based upon the initial input of Capital Strategies group and others, as well as our successful experience in other states such Rhode Island, we are confident that we will be able to negotiate a satisfactory set of conditions for this transaction.

1. **Assets to be Acquired.** We propose to form one or more new entities to purchase the assets of GWHN including all tangible and intangible assets owned or used by GWHN and its affiliates (other than the post-conversion Foundation).

We contemplate that the assets would be conveyed and assigned free and clear of all liens, claims, charges or encumbrances. Other than as set forth in Section 3 of this Letter, Prospect will not assume any liabilities except those liabilities specifically agreed to as part of definitive agreements for the transaction.

2. **Proposed Purchase Price.** Assuming that GWHN's consolidated balance sheet at closing would be free of all debt (including pension liabilities) and cash, Prospect is prepared to offer a total consideration of $100 million (based on GWHN's financial statements as presented to date) for the assets of GWHN as described above. The consideration is broken down as follows:

Consideration for Assets	$45 million
Capital Commitment	$55 million
Total	$100 million

After the closing, Prospect commits to spend at least $55 million within seven years on capital projects including routine and non-routine capital expenditures for the benefit of the facilities and operations of GWHN. The Capital Commitment shall be reduced by the amount of capital leases assumed at closing up to a maximum reduction of $3.0 million.

3. **Assumption of Pension and Other Liabilities.** Prospect shall assume GWHN's pension liability, capital lease obligations and asbestos abatement liability.

4. **Purchase Price Adjustment.** Subject to the terms and conditions of the definitive agreements, the consideration to be paid at closing shall be reduced by the amount of the pension liability, the amount of any capital leases assumed in excess of $3.0 million and all other liabilities assumed by Prospect. Furthermore, the consideration paid at close shall be increased or decreased, as the case may be, by an amount equal to the difference between the net working capital of GWHN at the time of the close and $6.8 million. By way of example, if the networking capital of GWHN is $7.8 million at the time of the closing, then the consideration paid at closing shall be increased by $1 million. However, if the networking capital of GWHN is $5.8 million at the time of the close, then the consideration paid at closing shall be decreased by $1 million.

5. **Other Facilities.** The transaction contemplated by this Letter shall not be contingent on Prospect purchasing any other hospital or healthcare facility not owned by GWHN.

6. Employees. We do not foresee any changes in the management of GWHN. It has been our practice and preference to rely on the existing strong management in place at the time of the transaction. In addition, Prospect will make all of its resources (both financial and human capital) available to GWHN's management team in order to execute on the strategic plan and develop a healthcare delivery system with population health management and accountable care capabilities. We anticipate hiring substantially all of the employees of GWHN who are active and in good standing at the time of the closing.

7. Medical Staff. Prospect would work with the local community advisory board, described below, and GWHN's medical staff members to preserve the existing staff membership and the current privileges of each physician as well as the medical staff leadership. Prospect is a physician-centric company and believes that the delivery of quality healthcare services depends on quality physicians.

We intend to develop a network of healthcare clinics and independent physician associations to support, enhance and implement the mission and vision of GWHN and to implement the CRC model. The establishment of a strong physician network necessarily requires the recruitment of additional high quality physicians to GWHN's medical staff. We intend to use our experience and physician alignment strategies in order to form lasting physician relationships.

Furthermore, we intend to support any existing initiatives and provide additional quality and safety expertise and protocols, as necessary, to achieve high satisfaction among patients, physicians, employees and volunteers. A commitment to excellence is of paramount importance to Prospect. Our desired culture is an environment which rewards teamwork, communication, accountability, learning and respect. Recent reimbursement changes and the advent of value-based purchasing programs emphasize the importance of quality and satisfaction across all constituents.

8. Governance. Prospect believes that the delivery of health care is local in nature and as such, Prospect depends on meaningful input from local community and physician leaders. Prospect is extremely flexible on issues relating to local governance. We propose to form a local community advisory board comprised of local community members and physicians. To that end, we welcome and encourage the continued involvement of the existing board members of GWHN with the advisory board post-closing. Generally, post-transaction, the Board of Directors for GWHN will receive input from a local advisory board. Pending further discussions with the current GWHN board, we propose the following:

(A) Board Representation. Post-transaction, Prospect will appoint a local community advisory board. A significant and pre-determined number of the members of the local community advisory board shall be members of the local community and practicing physicians. Prospect would prefer that at least some of the current members of the Board of Directors of GWHN agree to serve on such local community advisory board at the hospital. A member of the Board of Directors of the GWHN acquiring entity post transaction shall be a member of the local community advisory board. That way there is a

direct communication between the local community advisory board and the board of directors.

(B) Roles and Responsibilities of the Local Community Advisory Board. The local community advisory board shall serve in an advisory capacity to Board of Directors post transaction. The roles and responsibilities of the local community advisory board shall be as follows:

(i) Make recommendations and suggestions regarding the mission, vision and value statements with respect to GWHN post transaction;

(ii) make recommendations and suggestions with respect to medical staff credentialing, disciplinary action of staff physicians, and compliance with accreditation requirements;

(iii) provide input on policies and clinical programs;

(iv) provide input in the development and review of strategic plans;

(v) provide input on operating and capital budgets;

(vi) provide input and support physician recruitment efforts;

(vii) provide input on succession plans for executive leadership at the hospital;

(viii) promote community health initiatives, fostering community relationships and identifying service and education opportunities; and

(ix) monitor the commitment to maintain and improve quality indicators.

As stated above, since we value local input into operations, in addition to the above, we are amenable to other suggestions and/or proposals that the current GWHN Board of Directors may have regarding input and influence post business combination. We welcome GWHN's input on this matter.

9. Continuing Operations of Hospital. For a period of five years after the closing of the transaction, Prospect shall continue to provide essential services at the facilities and shall not merge, dissolve, consolidate, sell or otherwise dispose of the hospital without the consent of the GWHN or its designee, unless, in either case, to an Affiliate of Prospect; provided that this clause (i) shall not apply to (y) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or relates to a broader group of facilities or assets than the Hospital, or (z) any corporate-level transactions involving Prospect's assets, stock or securities, including mergers, recapitalizations or reorganizations.

10. Sale of Hospital within 3 years After the Close. In the event of a sale of all of the Facilities for cash, whether by merger, sale, or other transaction, at any time prior to the third

(3rd) anniversary of the Closing for a purchase price in excess of (a) the Purchase Price paid by Prospect for the assets of GWHN plus (b) the amount of any expenditures made by Prospect or its Affiliates with respect to the Facilities and their affiliated businesses in the Greater Waterbury region in such period, plus (c) any losses generated by the Facilities and its affiliated businesses in such period (such amount, the "Net Hospital Value"), then Prospect agrees to convey to Seller or its designee immediately upon closing of such transaction by wire transfer of immediately available funds in an amount equal to twenty percent (20%) of the difference between (i) the Net Hospital Value, and (ii) the cash purchase price paid to Prospect in connection with such subsequent sale transaction. Notwithstanding anything to the contrary this section shall not apply to (x) any sale required by a Governmental Entity, (y) any merger, sale or other transaction that does not relate solely or principally to the Greater Waterbury Hospital, or relates to a broader group of facilities or assets than the Facilities, or (z) any corporate-level transactions involving Prospect's stock or securities, including macro-level mergers, recapitalizations or reorganizations.

11. Charity Care. Prospect recognizes the importance of community service and charity care within the communities served by GWHN. Prospect is proud of its institutional tradition of providing charity care to uninsured and the under-insured members of its hospital communities. Subject to diligence, Prospect intends to adopt GWHN's charity care policies. Prospect will operate its charity care program in accordance with federal and state laws. Prospect will continue to provide medically necessary services to the surrounding communities served by GWHN.

12. Advance of Expenses. Prospect is aware of GWHN's desire for termination fees and/or an arrangement that includes the sharing of GWHN's costs with respect to this transaction. As GWHN is aware, Prospect has had a very limited period of time and very limited access to GWHN's data. Notwithstanding, Prospect agrees to the following:

(a) During the first thirty (30) days following the populating of the data room by GWHN critical diligence documents described in Exhibit A attached, each of Prospect and GWHN shall bear their own expenses pursuant to Section 15 below;

(b) Prospect shall, within 30 days of presentation of an invoice, reimburse GWHN for its direct out-of-pocket transaction costs in an amount up to $50,000 for each thirty (30) day period beginning upon the expiration of the thirty (30) day period described in Section 12(a) above, and ending on the date the Certificate of Need is filed with the Connecticut Department of Public Health; provided further, that (i) if expenses in any such thirty (30) day period are less than $50,000, the excess of $50,000 over such amount of expenses may be carried over to the next thirty (30) day period such that expenses subject to reimbursement in the following thirty (30) day period would be allowable up to $50,000 plus such carried over amount from the prior thirty (30) day period, and (ii) total expense reimbursement pursuant to this Section 12(b) shall not exceed $150,000;

(c) When the expense cap of $150,000 is reached in accordance with Section 12(b), Prospect and GWHN, each shall then bear their own expenses pursuant to Section 15;

(d) Should the proposed transaction close, then the amount of expenses reimbursed pursuant to Section 12(b) above shall be deducted from the purchase price paid by Prospect; and

(e) If at the end of the Exclusivity Period (as defined in Section 14), Prospect desires to move forward with a transaction on substantially the same economic terms as described above, and GWHN desires to not go forward with such a transaction, then GWHN shall repay Prospect for any funds reimbursed by Prospect pursuant to Section 12(b) above.

13. Conditions to Transaction. The Transaction Documents would include customary legal and business provisions mutually agreed upon by the parties. In addition to any other requirement set forth in this Letter of Intent, the consummation of the proposed transaction shall be subject to and contingent upon each of the following being satisfied at closing:

a. The negotiation and delivery of mutually satisfactory Transaction Documents;
b. Completion and satisfaction of the results of due diligence by Prospect, in its sole and absolute discretion;
c. The approval of the transaction by Prospect's board of directors, in its sole and absolute discretion; and
d. Receipt of any necessary governmental consents or approvals.

14. Exclusive Negotiations. GWHN and Prospect shall enter into exclusive negotiations regarding the proposed transaction. During the Exclusivity Period (as defined below), neither, GWHN nor any of their respective representatives, directly or indirectly, shall: (i) offer any of the assets described in this Letter of Intent for sale, lease or other disposition to any person or entity other than Prospect; (ii) merge, or conduct a business combination of any sort involving, GWHN or any of its affiliates with any other person or entity; (iii) transfer the membership, control, or any ownership interest in GWHN or any of its affiliates to any other person or entity; (iv) enter into a partnership or any other joint venture involving GWHN or any of its affiliates; (v) enter into any agreement with any person or entity other than Prospect with respect to any of the matters set forth in *(i)* through *(iv)* above; (vi) solicit, encourage (by way of furnishing non-public information or otherwise), negotiate, hold discussions regarding, entertain, accept, or take any other actions to facilitate, any offers regarding any of the matters or actions set forth in *(i)* through *(v)* above. The "Exclusivity Period" shall be the period beginning on the date that this Letter of Intent is signed by GWHN (the "Execution Date") and ending at 5:00 P.M. Eastern Time one hundred twenty (120) days after GWHN completes populating the data room (the "Expiration Date").

15. Expenses. Subject to paragraph 12, above, the parties acknowledge and agree that each party shall be responsible for its own expenses in connection with its individual assessment as to whether to proceed with the proposed transaction. Accordingly, each party shall pay for its own fees and expenses and those of its respective agents, representatives and advisors, including but not limited to all attorneys and accountants with respect to the negotiations of this Letter of

Intent, the negotiation of the Transaction Documents, and if the Transaction Documents are executed, the closing the transaction and any other transactions contemplated by the Transaction Documents. Notwithstanding the foregoing, in the event that Prospect and St. Mary's negotiate a transaction, GWHN shall not be responsible for any fees related to federal and state anti-trust reviews. All such costs related to an anti-trust review related to a transaction involving St. Mary's shall be the responsibility of St. Mary's or Prospect.

16. Entire Agreement; Future Modifications. Except for the Mutual Nondisclosure Agreement dated as of March 9, 2015 (the "Confidentiality Agreement"), this Letter of Intent constitutes the full and complete agreement and understanding between the parties hereto concerning the subject matter hereof and supersedes any prior written and oral agreements with regard to such subject matter. This Letter of Intent may be modified or waived only by a separate written agreement signed by the parties hereto.

17. Waiver. The rights and remedies of the parties to this Letter of Intent are cumulative and not alternative. Neither the failure nor any delay by any party in exercising any right, power, or privilege under this Letter of Intent shall operate as a waiver of such right, power, or privilege, and no single or partial exercise of any such right, power, or privilege shall preclude any other or further exercise of such right, power, or privilege or the exercise of any other right, power, or privilege. A waiver shall be applicable only in the specific instance for which it is given. To the maximum extent permitted by law (i) no claim or right arising out of this Letter of Intent can be discharged by one party, in whole or in part, by a waiver or renunciation of the claim or right unless in writing signed by the other party; (ii) no waiver that may be given by a party shall be applicable except in the specific instance for which it is given; and (iii) no notice to or demand on one party shall be deemed to be a waiver of any obligation of such party or of the right of the party giving such notice or demand to take further action without notice or demand as provided in this Letter of Intent.

18. Severability. The invalidity or unenforceability of any provision of this Letter of Intent shall not affect the validity or enforceability of any other provisions of this Letter of Intent, which shall remain in full force and effect. If any provision of this Letter of Intent is determined to be unenforceable by reason of its extent, duration, scope or otherwise, then the parties contemplate that the court making such determination shall reduce such extent, duration, scope or other provision and enforce them in their reduced form for all purposes contemplated by this Letter of Intent.

19. Costs. In the event of any action or other proceedings between or among the parties hereto with respect to the Binding Provisions (defined below), the non-prevailing party or parties to such action or proceedings shall pay to the prevailing party or parties all costs and expenses, including reasonable attorneys' and expert witness fees, incurred in the defense or prosecution thereof by the prevailing party or parties. The prevailing party shall be determined by the judge(s) or other person hearing the matter and shall be the party who is entitled to recover its costs of suit, whether or not the matter proceeds to a final judgment or award. A party not entitled to recover its costs of suit shall not recover attorneys' fees. If a prevailing party or parties shall recover a decision, judgment or award in any action or proceedings, the costs and

expenses awarded to such party or parties may be included in and as part of such decision, judgment or award.

20. Section Headings. The headings of the sections in this Letter of Intent are provided for convenience only and shall not affect its construction or interpretation.

21. Governing Law. This Letter of Intent shall be governed by the laws of the State of New Connecticut without regard to conflicts of laws principles with Connecticut courts having exclusive jurisdiction over any matters addressed in this Letter of Intent.

22. Counterparts. This Letter of Intent may be executed in two or more counterparts, each of which shall be deemed to be an original copy of this Letter of Intent, and all of which, when taken together, shall be deemed to constitute one and the same agreement.

23. Notices. All notices, requests, demands or other communications required or permitted to be given under this Letter of Intent shall be in writing and shall be delivered to the Party to whom notice is to be given, to the notice addresses set forth below, either (i) by personal delivery (in which case such notice shall be deemed given on the date of delivery), (ii) by next business day courier service (e.g., Federal Express, UPS or other similar service) (in which case such notice shall be deemed given on the business day following the date of deposit with the courier service), or (iii) by United States mail, first class, postage prepaid, certified, return receipt requested (in which case such notice shall be deemed given on the third (3rd) day following the date of deposit with the United States Postal Service).

If to GWHN:

Carl D. Contadini
c/o The Waterbury Hospital
64 Robbins St.
Waterbury, CT 06708

With a simultaneous copy to:

Ann H. Zucker, Esq.
Carmody Torrance Sandak & Hennessey LLP
707 Summer St
Stamford, CT 06901-1026

If to Prospect:

Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025
Attn.: Samuel S. Lee

With a simultaneous copy to counsel for Prospect:

Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025
Attn.: Ellen Shin, General Counsel

24. Due Diligence, Access to Information, Access to Facilities. Prospect has, conducted an initial review and examination of certain data and information with respect to the GWHN and its affiliates. The parties agree and acknowledge that Prospect requires further due diligence review and requires access to additional information and GWHN's facilities above and beyond that which has been provided to Prospect prior to the execution of this Letter of Intent. During the Exclusivity Period GWHN and its affiliates will provide Prospect with reasonable access to (i) information and materials related to GWHN, its affiliates and their respective related assets as requested by Prospect from time to time, and (ii) all real property, facilities and equipment that are part of the proposed transaction.

25. Confidentiality. The existence and terms of this Letter of Intent, and the matters contemplated herein, shall be subject to the terms and requirements of the Confidentiality Agreement.

26. Ordinary Course. Until the earlier of the closing of the proposed transaction or termination of this Letter of Intent, GWHN and its affiliates shall conduct business in the ordinary course of business and shall not sell or dispose of any asset other than in ordinary course.

27. Term. The term of this Letter of Intent shall commence as of the Execution Date and shall continue in effect during the Exclusivity Period unless extended by mutual agreement of the parties. Notwithstanding the foregoing, Prospect may elect to terminate this Letter at any time immediately upon written notice to GWHN and reimburse GWHN for any expenses in accordance with Section 12.

28. Binding Provisions. The obligations of GWHN and Prospect under Section 12, and Sections 14 through Section 29 (collectively, the "Binding Provisions"), shall be binding on all parties. All other provisions shall be non-binding on the parties.

29. Non-Binding With Respect to Consummation of Proposed Transaction. This Letter of Intent represents an expression of intent only with respect to the consummation of the proposed transaction. Accordingly, unless and until the Transaction Documents are executed and all other conditions to closing have been satisfied or waived, no party shall be obligated to consummate the proposed transaction. As a result, in the absence of the Transaction Documents or any other definitive agreements between the parties with respect to the proposed transaction, and subject to the Binding Provisions, none of the expiration or earlier termination of the Exclusivity Period, the failure by either Party to agree to extend the Exclusivity Period or the failure by either Party to agree to the Transaction Documents shall, in and of itself, give rise to any legally enforceable right or claim for damages or injunctive relief or any other form of judicially recognized award or right with respect to the proposed transaction or the consummation thereof. No past or future action, course of conduct, or failure to act relating to

the proposed transaction, or relating to the negotiations of the terms of the Transaction Documents, will give rise to or serve as a basis for any obligation or other liability on the part of any party. The parties acknowledge and agree that this Letter of Intent is an expression made in good faith by Prospect regarding Prospect's intentions. The omission of certain terms from this Letter of Intent shall not be construed so as to diminish the importance or the materiality of such term, and the parties acknowledge that, in addition to the proposed terms contained in this Letter of Intent, additional material terms remain to be resolved. It shall remain in the sole and absolute discretion of each party whether or not to enter into any definitive agreements or transactions with the other party, or parties, and no party shall have any liability or obligation for failing to do so except as expressly provided in this Letter of Intent.

If this Letter of Intent is acceptable to GWHN, we ask that GWHN please sign and date this Letter of Intent where indicated below. Please return an originally signed and completed copy of this Letter of Intent to me. This Letter of Intent shall have no force or effect if not executed and returned to Prospect prior to 5:00 p.m. Eastern Standard Time on May 4, 2015.

We look forward to working with you.

Very truly yours,
PROSPECT MEDICAL HOLDINGS, INC.

Samuel S. Lee
Chief Executive Officer

Accepted and Agreed.

Greater Waterbury Health Network

By: Carl D Contadini

Name: CARL D CONTADINI

Title: CHAIRMAN GWHN

Dated: 5-1-2015

Exhibit A

1. Audited Financial statements for the past two years
2. Most recent unaudited interim financial statement and the statements for the corresponding period of the previous fiscal year
3. Identification of all one-time revenue and expense items for the past two years and YTD.
4. Last fiscal year and YTD detailed financial statements
5. Current year budget, including Capital expenditure budget
6. Any reports, studies and projections prepared internally or externally on the GWHN's financial condition and planned operations
7. Most recent marketing and/or strategic plans
8. Contracts with Unions and other labor agreements
9. Summary of annual occupancy, CMI, length of stay and other census trending reports detailed by payer mix and by program for 2013, 2014 and YTD 2015
10. Board of Director statistics and reports prepared by GWHN management to describe the financial condition of GWHN
11. Actuarial reports related to all pension plans
12. Identified strategic growth and cost initiatives
13. Copies of corporate integrity agreements, or any similarly mandated corporate compliance programs imposed by any state or federal regulatory authority along with all settlement agreements currently in effect, in process of negotiations, or that were in effect in past 3 years
14. Summary of any regulatory investigations currently active or conducted within the last three years involving GWHN by any federal or state regulatory authorities including copies of findings and corrective action plans
15. Summary of E.H.R. meaningful use implementation
16. Description of ICD-10 implementation / readiness
17. Most recent marginal cost or marginal contribution analyses on any and all programs
18. Medicare Cost reports for the past 2 years
19. All third party valuations on GWHN's properties.
20. Admissions by physician for past 12 months
21. Admissions / Discharges by financial class for past 12 months
22. ER conversion rate by financial class
23. Outlier and transfer DRG reports
24. Medicare and Medicaid admissions by DRG and length of stay
25. Admissions by source
26. Labor productivity reports for the past 12 months
27. Top 20 vendors for purchase services (other than supplies)
28. Top 20 supply item purchases and per unit cost

AMENDMENT NO. 1 TO LETTER OF INTENT

This AMENDMENT NO. 1 TO LETTER OF INTENT (this "Amendment") is made as of the 28th day of August, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("Seller").

WHEREAS, PMH and Seller are parties to that certain Letter of Intent dated April 30, 2015 (the "LOI"); and

WHEREAS, the parties have agreed to extend the "exclusivity provision" of the LOI.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Paragraph 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on September 8, 2015.

2. Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the LOI.

3. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By:_____
Name:
Title:

GREATER WATERBURY HEALTH NETWORK, INC.

By:_____
Name: DARLENE STRONSTAD
Title: Pres/CEO

AMENDMENT NO. 2 TO LETTER OF INTENT

This AMENDMENT NO. 2 TO LETTER OF INTENT (this "Amendment") is made as of the 10 day of September, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("Seller").

WHEREAS, PMH and Seller are parties to that certain Letter of Intent dated April 30, 2015 (as amended on August 28, 2015, the "LOI"); and

WHEREAS, the parties have agreed to extend the "exclusivity provision" of the LOI.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Paragraph 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on September 15, 2015.

2. Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the LOI.

3. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By: _____
Name: Sam Lee
Title: CEO

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____
Name: Darlene Stromstad
Title: Pres/CEO

AMENDMENT NO. 3 TO LETTER OF INTENT

This AMENDMENT NO. 3 TO LETTER OF INTENT (this "Amendment") is made as of the 14 day of September, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("Seller").

WHEREAS, PMH and Seller are parties to that certain Letter of Intent dated April 30, 2015 (as previously amended on August 28, 2015, and on September 10, 2015, the "LOI"): and

WHEREAS, the parties have agreed to extend the "exclusivity provision" of the LOI.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Paragraph 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on October 5, 2015.

2. Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the LOI.

3. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By: _____
Name: SAMUEL S. LEE
Title: CHIEF EXECUTIVE OFFICER

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____
Name: DARLENE STRONSTAD
Title: Pres/CEO

EXECUTION VERSION

AMENDMENT NO. 4 TO LETTER OF INTENT

This AMENDMENT NO. 4 TO LETTER OF INTENT (this "Amendment") is made as of the 27 day of October, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("PMH"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("GWHN").

WHEREAS, PMH and GWHN are parties to that certain Letter of Intent dated April 30, 2015, as amended by that certain Amendment No. 1 to Letter of Intent dated August 28, 2015, by that certain Amendment No. 2 to Letter of Intent dated September 10, 2015, and by that certain Amendment No. 3 to Letter of Intent dated September 14, 2015 (as so amended, the "LOI"); and

WHEREAS, the parties have agreed to reaffirm their respective obligations thereunder and to make certain amendments thereto to include mutually agreed upon binding covenants of the parties that will be effective until the Expiration Date.

NOW, THEREFORE, in consideration of the mutual covenants, terms, conditions, privileges and obligations set forth herein, and intending to be legally bound hereby, the parties hereto mutually agree as follows:

1. Section 14 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on the earlier of (x) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the Letter of Intent, and (y) ninety (90) days following the receipt by the parties of the certificate of need approval for The Waterbury Hospital ("Hospital") by the Office of Healthcare Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Office of the Attorney General of the State of Connecticut (the "Expiration Date"); provided, however, that, notwithstanding the receipt of such approvals, Prospect shall have the right, if Prospect is diligently contesting in good faith any of the terms or conditions of such approvals, including, without limitation, pursuing any changes in respect of the conditions imposed on the operation of the Hospital or the related businesses or any other modifications set forth in such approval, (a) exercisable upon prior written notice to GWHN, to extend the Expiration Date by up to an additional thirty (30) days; and (b) with the written consent of GWHN, to extend the Expiration Date by such longer period as the parties may agree upon.

2. Section 28 of the LOI shall be deleted in its entirety and replaced with the following:

"28. **Binding Provisions**. The obligations of GWHN and Prospect under Section 12, and Section 14 through Section 30 (collectively, the "Binding Provisions"), shall be binding on all parties. All other provisions shall be non-binding on the parties."

3. The first sentence of Section 29 of the LOI shall be deleted in its entirety and replaced with the following:

"29. **Non-Binding With Respect to Consummation of Proposed Transaction.** Except as otherwise set forth in this Letter of Intent, and subject to the Binding Provisions, this

Letter of Intent represents an expression of intent only with respect to the consummation of the proposed transaction."

The remainder of Section 29 shall remain in full force and effect.

4. A new Section 30 of the LOI is hereby added immediately following Section 29 of the LOI, as follows:

"30. **Covenants.** Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in Annex A hereto.

(a) Access to and Provision of Additional Information.

(i) GWHN shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Prospect full and complete access to and the right to inspect the plants, properties, books, and records of the Hospital Businesses, and will furnish Prospect with such additional financial and operating data and other information as to the business and properties of GWHN pertaining to the Hospital Businesses as Prospect may from time to time reasonably request without regard to where such information may be located. Prospect's right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Hospital Businesses and the delivery of patient care. Prospect agrees that no inspections shall take place and no employees or other personnel of the Hospital Businesses shall be contacted by Prospect without Prospect's first providing reasonable notice to GWHN and coordinating such inspection or contact with GWHN.

(ii) Within two (2) business days after they are created (but in any event no later than fifteen (15) days following the end of each calendar month prior to the Expiration Date), GWHN shall deliver or cause to be delivered to Prospect true and complete copies of the management prepared unaudited balance sheets and the related unaudited statements of income of, or relating to, GWHN and its Wholly Owned Subsidiaries in respect of the Hospital Businesses for each month then ended, which presentation shall be true, correct, and complete in all material respects, shall have been prepared from and in accordance with the books and records of GWHN and its Wholly Owned Subsidiaries in respect of the Hospital Businesses, and shall fairly present the financial position and results of operations of GWHN and its Wholly Owned Subsidiaries in respect of the Hospital Businesses as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such financial statements need not include required footnote disclosures. To the extent permitted by law, GWHN shall notify Prospect in writing and shall keep Prospect informed of any unexpected emergency or other materially adverse unanticipated change in the business of any of the Hospital Businesses and of any governmental complaints,

investigations, or adjudicatory proceedings (or governmental communications indicating that the same may be contemplated) or of any other such matter.

(iii) Until the Expiration Date, to the extent permitted by law, GWHN shall confer regularly with Prospect, as reasonably requested by Prospect, and answer Prospect's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Letter of Intent. GWHN shall notify Prospect of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, grievances, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Prospect reasonably informed of the status of such matters.

(iv) With respect to any individually identifiable health information disclosed by GWHN to Prospect pursuant to this Section, Prospect and GWHN shall comply with HIPAA and with any other Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

(v) For the avoidance of doubt, Prospect shall not, and nothing contained in this Section shall give Prospect, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the closing of the transactions contemplated by this Letter of Intent.

(b) Governmental Approvals.

(i) GWHN's Obligations.

(1) GWHN shall (A) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow GWHN to perform its obligations under this Letter of Intent (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein); and (B) assist and cooperate with Prospect and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Prospect deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that

Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein).

(2) GWHN shall, if and to the extent required by Legal Requirements, file all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Letter of Intent. GWHN agrees to furnish to Prospect such information concerning GWHN as Prospect needs to perform its obligations under Section 30(b)(ii)(2) of this Letter of Intent.

(ii) Prospect's Obligations.

(1) Prospect shall (A) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Prospect to perform its obligations under this Letter of Intent (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein), and (B) assist and cooperate with GWHN and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that GWHN deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by GWHN to Prospect and/or any other projects or activities in the community that Prospect, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein). Prospect shall pay all of the costs of any fees due in respect of filings made to the Attorney General and Commissioner of Public Health of the State of Connecticut, including, without limitation, fees required to be paid by Prospect pursuant to CT Gen Stat § 19a-486c(c) and CT Gen Stat § 19a-486d(a) shall remain the obligation of Prospect.

(2) Prospect shall, if and to the extent required by Legal Requirements, file or cause to be filed all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the

transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Letter of Intent. Prospect agrees to furnish to GWHN such information concerning Prospect as GWHN needs to perform its obligations under Section 30(b)(i)(2) of this Letter of Intent. Prospect shall pay the costs of any fees due in respect of filings required by the HSR Act.

(c) Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Letter of Intent, whenever this Letter of Intent requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

(d) CON Disclaimer. This Letter of Intent shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate Governmental Authority shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

(e) Fees and Expenses.

(i) Except as otherwise expressly set forth in this Letter of Intent, whether or not the transactions contemplated by this Letter of Intent are consummated, (1) Prospect or its Affiliates shall bear and pay all expenses incurred by or on behalf of Prospect in connection with Prospect's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Letter of Intent and Prospect's performance of its obligations pursuant to this Letter of Intent, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (2) GWHN shall bear and pay all expenses incurred by or on behalf of GWHN, or its Affiliates or Wholly Owned Subsidiaries, in connection with the preparation and negotiation of this Letter of Intent and GWHN's performance of its obligations pursuant to this Letter of Intent, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(ii) GWHN shall pay all costs reasonably necessary for GWHN to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by GWHN in obtaining any third party consents or approvals necessary to assign to Prospect any Assumed Contracts (it being understood that GWHN shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than $1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(iii) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Letter of Intent and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled."

5. A new Section 31 of the LOI is hereby added immediately following Section 30 of the LOI:

"31. **Asset Purchase Agreement**. The parties agree to use the Asset Purchase Agreement attached hereto as Annex B, in substantially similar form, subject to any revisions that may be necessary or appropriate, in Prospect's reasonable discretion, based on its due diligence."

6. A new Section 32 of the LOI is hereby added immediately following Section 31 of the LOI, as follows:

"32. **Not a Sale of a Hospital**. Notwithstanding anything to the contrary set forth herein, this Letter of Intent shall not constitute, or be deemed to constitute, an agreement to transfer a material amount of a nonprofit hospital's assets or operations or a change in control of a hospital's operations, it being expressly understood that no such agreement shall be entered into without first having received approval of such agreement by the Commissioner of Public Health of the State of Connecticut and the Attorney General."

7. Where the context requires, references to "*this Letter of Intent*" or "*this Letter*" mean the LOI, as amended by this Amendment, and all Annexes and Schedules attached to or referenced in this LOI;

8. Except as expressly modified by this Amendment, all other terms, conditions, covenants and obligations of the LOI shall remain in full force and effect.

[Signature Page Follows]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

GREATER WATERBURY HEALTH NETWORK, INC.

By:_____
Name: Darlene Stromstad
Title: Pres/CEO

[*Signature page to Amendment No. 4 to Letter of Intent*]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first written above.

PROSPECT MEDICAL HOLDINGS, INC.

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

GREATER WATERBURY HEALTH NETWORK, INC.

By:_____
Name:
Title:

[Signature page to Amendment No. 4 to Letter of Intent]

Annex A

Certain Definitions

(1) **Affiliate** means as to the Person in question, any Person that directly or indirectly controls, is controlled by, or is under common control with the Person in question, and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through ownership of voting securities, by contract, or otherwise;

(2) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by GWHN wherever located and whether or not reflected in the financial statements of GWHN and its Wholly Owned Subsidiaries.

(3) **Assumed Contracts** means the Contracts, the leases relating to the Leased Real Property, the leases relating to the leased personal property, and all Immaterial Contracts not specifically designated by Prospect as an Excluded Contract at or prior to the closing of the transactions contemplated by this Letter of Intent;

(4) **Attorney General** means the Office of the Attorney General of the State of Connecticut;

(5) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which GWHN or any Wholly Owned Subsidiary of GWHN is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retirement, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(6) **Converted Ventures** means the Non-Profit JVs that have been converted to new for-profit entities;

(7) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, easements, restrictions, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(8) **Excluded Contracts** means the commitments, contracts, leases, and agreements other than the Assumed Contracts;

(9) **FTC** means the United States Federal Trade Commission;

(10) **GAAP** means United States generally accepted accounting principles;

(11) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(12) **HIPAA** means the federal Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, as amended;

(13) **Hospital** means The Waterbury Hospital (a tax-exempt entity), an acute care teaching hospital having 357 licensed beds;

(14) **Hospital Businesses** means the entities and businesses operated by GWHN and its Wholly Owned Subsidiaries, including the Hospital; *provided*, that, for the avoidance of doubt, the parties hereby agree and acknowledge that the term "Hospital Businesses" does not include the Joint Ventures or Converted Ventures or any of their health care facilities, assets or businesses;

(15) **HSR Act** means the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(16) **Immaterial Contract** means any Contract to which GWHN or any of its Wholly Owned Subsidiaries is a party that requires either the payment by GWHN or its Wholly Owned Subsidiaries of $25,000 or less or the provision of goods or the performance of services by GWHN or any of its Wholly Owned Subsidiaries having a value of $25,000 or less, in either case during the period from the date of this Letter of Intent until (i) if the Contract is terminable at any time by GWHN or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if GWHN or the respective Wholly Owned Subsidiary was to give notice of termination on the date of this Letter of Intent, or (ii) if the Contract is not terminable at any time by GWHN or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract that may otherwise be deemed material by the parties;

(17) **Joint Ventures** means Access Rehab Centers, LLC, Greater Waterbury Imaging Center, LP, Imaging Partners, LLC, Heart Center of Greater Waterbury, Inc., The Harold Leever Regional Cancer Center, Inc., Waterbury Gastroenterology Co-Management Company, LLC, and Valley Imaging Partners, LLC;

(18) **Justice Department** means the United States Department of Justice;

(19) **Leased Real Property** means the real property, together with all buildings, improvements and fixtures thereon, that is leased by GWHN or any Wholly Owned Subsidiaries of GWHN;

(20) **Legal Requirements** means, with respect to any Person, all federal, state and local statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, policies, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(21) **Non-Profit JVs** means Heart Center of Greater Waterbury, Inc. and The Harold Leever Regional Cancer Center, Inc.;

(22) **Permitted Encumbrances** means those Encumbrances identified by the parties prior to the closing of the transactions contemplated by this Letter of Intent as being Permitted Encumbrances;

(23) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(24) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(25) **Wholly Owned Subsidiary** means, with respect to any Person, (i) any corporation 100% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Wholly Owned Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Wholly Owned Subsidiaries of such Person has a 100% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Wholly Owned Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (a) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (b) whose sole member is such Person; *provided*, *however*, that with respect to GWHN, includes, without limitation, the Hospital, Greater Waterbury Health Services, Inc., VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc., Children's Center of Greater Waterbury Health Network, Inc., Alliance Medical Group, Inc., and Cardiology Associates of Greater Waterbury, LLC;

(26) Certain References. As used in this Letter of Intent:

ii. references to "*this Letter of Intent*" or "*this Letter*" mean the LOI, as amended by that certain Amendment No. 1 to Letter of Intent dated August 28, 2015, by that certain Amendment No. 2 to Letter of Intent dated September 10, 2015, by that certain Amendment No. 3 to Letter of Intent dated September 14, 2015, and as further amended by this Amendment, and all Annexes and Schedules attached to or referenced in this LOI;

iii. references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Letter of Intent, unless the context states or implies otherwise;

iv. references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

v. references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

vi. references to "*partnerships*" include general and limited partnerships;

vii. references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

viii. references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

ix. references to time are references to Eastern Time;

x. references to "*GWHN's Knowledge*," "*Knowledge of GWHN*," or words of similar intent or effect mean and refer to (x) all matters with respect to which GWHN or any of its Wholly Owned Subsidiaries has received written notice, and (y) the knowledge of each of the Persons whose names or titles are set forth on Schedule A, after due inquiry by GWHN (or Wholly Owned Subsidiary, as applicable) of such Persons;

xi. the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

xii. the use of captions and headings in connection with this Letter of Intent is solely for convenience and has no legal effect in construing this Letter of Intent.

Annex B

[Attach Asset Purchase Agreement]

INTENTIONALLY OMITTED

Schedule A

Persons with "GWHN's Knowledge"

[●]	President and Chief Executive Officer
[●]	Senior Vice President and Chief Operating Officer
[●]	Vice President/Chief Financial Officer
[●]	Vice President Medical Affairs/Chief Medical Officer
[●]	Vice President Patient Care/Chief Nursing Officer
[●]	Vice President Information Services/Chief Information Officer
[●]	Chief Medical Information Officer
[●]	Vice President Human Resources
[●]	Director – Compliance and HIPAA
[●]	Assistant Director Finance – Corporate Accounting
[●]	Corporate Compliance Officer
[●]	Administrative Director Facility Operations

EXHIBIT Q3-2

DRAFT ASSET PURCHASE AGREEMENT

ASSET PURCHASE AGREEMENT

by and between

GREATER WATERBURY HEALTH NETWORK, INC.

SELLER

and

[●]

BUYER

Dated as of [●], 2015

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ASSET PURCHASE AGREEMENT

This **ASSET PURCHASE AGREEMENT** (this "**Agreement**"), dated _____, 2015, is by and between Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("**Seller**"), on its behalf and on behalf of its Wholly Owned Subsidiaries, and [●], a Connecticut corporation ("**Buyer**"), with Prospect Medical Holdings, Inc. ("**PMH**"), a Delaware corporation and the indirect owner of Buyer, joining for the limited purposes described herein.

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of the Seller and its Wholly Owned Subsidiaries, including The Waterbury Hospital (a tax-exempt entity), an acute care teaching hospital having 357 licensed beds (the "**Hospital**"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc., Alliance Medical Group, Inc., and Cardiology Associates of Greater Waterbury, LLC (the entities and businesses operated by Seller and its Wholly Owned Subsidiaries, including the Hospital, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Access Rehab Centers, LLC, Greater Waterbury Imaging Center, LP, Imaging Partners, LLC, Heart Center of Greater Waterbury, Inc., The Harold Leever Regional Cancer Center, Inc., Waterbury Gastroenterology' Co-Management Company, LLC, and Valley Imaging Partners, LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**"); *provided*, that, for the avoidance of doubt, the parties hereby agree and acknowledge that the term "Hospital Businesses" does not include the Joint Ventures or Converted Ventures (as such term is hereinafter defined) or any of their health care facilities, assets or businesses;

WHEREAS, Buyer desires to purchase substantially all of the assets, real, personal and mixed, tangible and intangible, of Seller and the Wholly Owned Subsidiaries, including the Hospital Businesses and the equity interests in the Joint Ventures and Converted Ventures; and

WHEREAS, Seller has concluded that the transactions contemplated by this Agreement are in its best interests and consistent with its charitable mission of the promotion of health care in the communities served by the Hospital Businesses.

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which are forever acknowledged, the parties, intending to be legally bound, agree as follows:

AGREEMENT:

1. DEFINITIONS AND REFERENCES

1.01. Definitions. For purposes of this Agreement, the following definitions apply:

(1) **20-Day Period** is defined in Section 2.05(f);

(2) **Accessibility Laws** is defined in Section 3.11(b)(iv);

(3) **Accountants' Determination** is defined in Section 2.05(f);

(4) **Accounts Receivable** means all accounts, notes, interest, and other receivables of the Hospital Businesses, including, without limitation, those certain accounts, notes, or other receivables listed on Schedule 1.01(4), and all claims, rights, interests, and proceeds related thereto, including all accounts and other receivables, disproportionate share payments, and all rights to receive funds relating to upper payment limits, arising from the rendering of services to inpatients and outpatients at the Hospital Businesses, billed and unbilled, recorded and unrecorded, accrued and unaccrued, for services provided by Seller or the Wholly Owned Subsidiary, as applicable, while owner of the Assets, whether payable by private pay patients, private insurance, third party payors, Government Payment Programs, or by any other source, and accounts that have been written off, but excluding all Cost Report settlement amounts;

(5) **Accumulated Benefit Obligation**[1] means the accumulated benefit obligation of Seller's **[or its Wholly Owned Subsidiary's]**[2] defined benefit pension plan, the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan, determined for purposes of Seller's audited financial statements as of [•, 20__] using GAAP (i) reflecting the assumptions used for purposes of **[Note •]** of such financial statements (as updated for the RP-2014 mortality tables prepared by the Society of Actuaries) and (ii) assuming continuation of the Seller's **[or its Wholly Owned Subsidiary's]** post-retiree health benefit plan and no change in its provisions after [•, 20__] (other than the freeze of such plan to new participation) **[TO BE UPDATED BASED ON DILIGENCE]**;

(6) **AEA** is defined in Section 3.12;

(7) **Affiliate** means as to the Person in question, any Person that directly or indirectly controls, is controlled by, or is under common control with the Person in question, and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Person, whether through ownership of voting securities, by contract, or otherwise;

(8) **Agreement** is defined in the preamble;

(9) **Arbitrating Accountants** is defined in Section 2.05(f);

(10) **Asbestos Abatement Liability** means the amount reflected in Seller's audited financial statements;

(11) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets owned by a

[1] Subject to due diligence
[2] Subject to due diligence

Wholly Owned Subsidiary of Seller and the JV Interests, but (ii) excluding the Excluded Assets;

(12) **Assignment and Assumption Agreement** is defined in Section 9.02(c);

(13) **Assumed Contracts** is defined in Section 2.01(f);

(14) **Assumed Liabilities** is defined in Section 2.03;

(15) **Attorney General** means the Office of the Attorney General of the State of Connecticut;

(16) **Audited Financial Statements** means the audited consolidated balance sheets of Seller and its Wholly Owned Subsidiaries for the three most recently ended fiscal years, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and the report thereon of Marcum, LLP, independent certified public accountants;

(17) **Balance Sheet Date** is defined in Section 3.06(a);

(18) **Bill of Sale** is defined in Section 9.01(b);

(19) **Buyer** is defined in the preamble;

(20) **Buyer Deductible** is defined in Section 10.04;

(21) **Buyer's Indemnified Persons** means Buyer and its respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(22) **Capital Amount** means Fifty-One Million Five Hundred Thousand Dollars ($51,500,000) less the amount of Capital Lease Obligations assumed by Buyer at Closing in excess of Six Million Five Hundred Thousand Dollars ($6,500,000);

(23) **Capital Lease Obligations** means [_____];

(24) **Cash Balance Plan** is defined in Section 8.11;

(25) **CERCLA** is defined in Section 3.12;

(26) **Claim Notice** means written notification of a Third Party Claim by an Indemnitee to an Indemnifying Party under Article 9, including a Third Party Claim set forth in a "Revenue Agent's Report," "Statutory Notice of Deficiency," "Notice of Proposed Assessment," or any other official written notice from a Taxing authority that Taxes are due or that a Tax audit will be conducted;

(27) **Closing** is defined in Section 9.01(a);

(28) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Wholly Owned Subsidiaries as of the close of business on the Closing Date, which, for the avoidance of doubt, shall include Unfunded Pension Liabilities as a line item thereon, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

(29) **Closing Date** means the date upon which the Closing occurs;

(30) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing;

(31) **CMS** means The Centers for Medicare and Medicaid Services;

(32) **COBRA** means the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;

(33) **Code** means the Internal Revenue Code of 1986, as amended;

(34) **Commitment Amount** is defined in Section 6.9;

(35) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which Seller or any Wholly Owned Subsidiary of Seller is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retirement, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(36) **Converted Venture** is defined in Section 5.19;

(37) **Cost Reports** is defined in Section 6.06;

(38) **CTDEEP** is defined in Section 5.06;

(39) **DOL** means the United States Department of Labor;

(40) **DSH** means a Disproportionate Share Hospital that serves a significantly disproportionate number of low-income patients and receives payments from CMS to cover the costs of providing care to uninsured patients;

(41) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with GAAP consistently applied;

(42) **ECAF** is defined in Section 5.06;

(43) **EFT Account** is defined in Section 2.01(o);

(44) **Employee Benefit Plan** is defined in Section 3.21;

(45) **Employee Lists** is defined in Section 5.03(b);

(46) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, easements, restrictions, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(47) **Environmental Laws** is defined in Section 3.12;

(48) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended;

(49) **ERISA Affiliate** is defined in Section 3.21;

(50) **Essential Service** is defined in Exhibit C;

(51) **Establishment Real Properties** is defined in Section 5.06;

(52) **Excluded Assets** is defined in Section 2.02;

(53) **Excluded Contracts** is defined in Section 2.02(p);

(54) **Excluded Liabilities** is defined in Section 2.04;

(55) **Final Closing Statement** is defined in Section 2.05(e);

(56) **Final Determination Date** means the earliest to occur of (i) the twenty-first (21st) business day following the receipt by Seller of the Final Closing Statement and Closing Balance Sheets if Seller shall have failed to deliver the Objection Notice to Buyer within the 20-Day Period, (ii) the date on which Seller gives Buyer written notice to the effect that Seller has no objection to Buyer's determination of the amount of the actual Net Working Capital and actual Unfunded Pension Liabilities, (iii) the date on which Buyer and Seller execute and deliver a Settlement Agreement, (iv) the date as of which Buyer and Seller shall have received the Accountants' Determination, and (v) Buyer's failure to deliver the information set forth in Section 2.05(e) within the ninety (90) day period described therein.

(57) **Financial Statements** is defined in Section 3.06;

(58) **FTC** means the United States Federal Trade Commission;

(59) **GAAP** means United States generally accepted accounting principles;

(60) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(61) **Government Payment Programs** means federal and state Medicare, Medicaid, CHAMPUS and TRICARE programs, the Connecticut HUSKY Health program, and similar or successor programs with or for the benefit of Governmental Authorities;

(62) **Hazardous Substances** means and includes polychlorinated biphenyls, urea formaldehyde, asbestos, low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, and any substances, materials, constituents, chemicals, pollutants, contaminants, wastes (including medical waste), toxic substances, petroleum and petroleum products, or other elements or products that are included under or regulated by any Environmental Law, including, without limitation, CERCLA, RCRA and AEA;

(63) **Hill-Burton Act** means the federal Public Health Service Act, 42 U.S.C. §291, *et seq.*, as amended;

(64) **HIPAA** means the federal Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, as amended;

(65) **Hospital** is defined in the recitals;

(66) **Hospital Businesses** is defined in the recitals;

(67) **HSR Act** means the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(68) **Immaterial Contract** means any Contract to which Seller or any of its Wholly Owned Subsidiaries is a party that requires either the payment by Seller or its Wholly Owned Subsidiaries of $25,000 or less or the provision of goods or the performance of services by Seller or any of its Wholly Owned Subsidiaries having a value of $25,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller or the respective Wholly Owned Subsidiary was to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Wholly Owned Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Section 3.17;

(69) **Indemnifying Party** means any Person obligated to indemnify another Person under Article 10;

(70) **Indemnitee** means any Person entitled to indemnification under Article 9;

(71) **Indemnification Holdback Amount** means an amount equal to Four Million Five Hundred Thousand Dollars ($4,500,000) withheld by Buyer at the Closing and held by Buyer pursuant to the terms of this Agreement for (i) any shortfall amounts due to Buyer pursuant to Section 2.05(h), and (b) any Losses reimbursed to Buyer's Indemnified Persons pursuant to Section 10.01 and Section 10.09;

(72) **Indemnification Holdback Survival Date** is defined in Section 10.09(b);

(73) **Indemnity Notice** means written notification of a claim for indemnity under Article 10, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to Section 10.05(b);

(74) **Information Systems** means the software (including object and source codes as applicable), hardware, application programs and similar systems owned, licensed or leased by Seller or its Wholly Owned Subsidiary and used in the ownership or operation of any of the Hospital Businesses, whether or not on a system-wide basis;

(75) **Intellectual Properties** means (i) all inventions (whether or not patentable or reduced to practice), all improvements thereto, and all patents, patent applications, and patent disclosures, together with all reissuances, continuations, continuations-in-part, revisions, extensions, and reexaminations thereof, (ii) all trademarks, service marks, trade dress, logos, trade names, corporate names, domain names, and all websites (together with the content therein), including all goodwill associated therewith, and all applications, registrations, and renewals in connection therewith, (iii) all copyrightable works, all copyrights, and all applications, registrations, and renewals in connection therewith, and (iv) all trade secrets and confidential business information (including ideas, research and development, know-how, formulas, compositions, manufacturing and production processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals) that are owned, licensed or leased by Seller or its Wholly Owned Subsidiaries and used in the ownership or operation of the Hospital Businesses, together with all rights to sue or make any claims for any past, present, or future infringement, misappropriation or unauthorized use of any of the foregoing rights, and the right to all income, royalties, damages and other payments that are now or may hereafter become due or payable with respect to any of the foregoing rights, including damages for past, present or future infringement, misappropriation or unauthorized use thereof;

(76) **Interim Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Wholly Owned Subsidiaries as of the most recent month end available before the Closing;

(77) **IRS** means the United States Internal Revenue Service;

(78) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments

in any other Person, or membership in a not-for-profit business organization, and proceeds from the sale thereof;

(79) **Joint Commission** is defined in Section 3.16;

(80) **Joint Ventures** is defined in the recitals;

(81) **JV Interests** is defined in Section 2.01(q);

(82) **Justice Department** means the United States Department of Justice;

(83) **Leased Personal Property** is defined in Section 2.01(c)(ii);

(84) **Leased Real Property** means the real property, together with all buildings, improvements and fixtures thereon, that is leased by Seller or any Wholly Owned Subsidiaries of Seller;

(85) **Legal Requirements** means, with respect to any Person, all federal, state and local statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, policies, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(86) **Loan Agreement** is defined in Section 5.15;

(87) **Local Board** is defined in Section 6.12;

(88) **Losses** means any and all damages, costs, losses (including any diminution in value), liabilities, expenses or obligations (including Taxes, interest, penalties, court costs, costs of preparation and investigation, and attorneys', accountants' and other professional advisors' fees and expenses);

(89) **Material Adverse Effect** means any event, change, or occurrence that, individually or together with any other event, change, or occurrence, would reasonably be expected to have a material adverse effect on the Assets (whether or not covered by insurance) or on the business, operations, results of operations, prospects, or condition (financial or otherwise) of the Hospital Businesses; *provided, however*, that the definition of "Material Adverse Effect" shall be used solely for interpreting Section 8.04 and not for interpreting the phrase "material adverse effect" or "material adverse change" as such phrases may be used in any other context elsewhere in this Agreement; and further provided, that the following will be presumed ***not to constitute a Material Adverse Effect***: (a) general economic or industry conditions generally applicable to hospitals or healthcare facilities within the United States of the State of Connecticut so long as such conditions do not disproportionately affect Seller and the Hospital Businesses; (b) changes or proposed changes to any state or federal law, reimbursement rates or policies of Governmental Authorities that are generally applicable to hospitals or to health care facilities within the United States so long as such changes do not disproportionately affect Seller and the Hospital Businesses; (c) requirements, reimbursement rates, policies,

or procedures of third party payors or accreditation commissions or organization that are generally applicable to hospitals or health care facilities within the United States; (d) changes in GAAP; (e) actions specifically required of the parties pursuant to this Agreement; and (f) the "Trailing EBITDA" shall be not less than 80% of the normalized Trailing EBITDA of the same period for the prior year; *provided, however*, that if the "Trailing EBITDA" is less than 80% of the normalized Trailing EBITDA of the same period for the prior year, then such occurrence shall constitute a Material Adverse Effect;

(90) **Material Tangible Assets** means any equipment or other material items of tangible property and assets with an original cost in excess of $250,000;

(91) **Multiemployer Plan** is defined in Section 3.21;

(92) **Net Hospital Value** is defined in Section 6.08;

(93) **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Seller and its Wholly Owned Subsidiaries acquired by Buyer, including inventory and supplies, drugs, food, Accounts Receivable, other receivables, advance payments, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time), and Net Working Capital shall be calculated in accordance with the methodology set forth on Annex A attached hereto;

(94) **Non-Profit JVs** means Heart Center of Greater Waterbury, Inc. and The Harold Leever Regional Cancer Center, Inc.;

(95) **Notice Period** is defined in Section 10.05(a)(i);

(96) **Objection Notice** is defined in Section 2.05(f);

(97) **Owned Real Property** means real property that is owned (legally or beneficially) by Seller or any Wholly Owned Subsidiary, together with all buildings, improvements and fixtures thereon owned by Seller or any Wholly Owned Subsidiary of Seller, all construction in progress, and all appurtenances, rights, privileges and easements thereto;

(98) **PBGC** means the Pension Benefit Guaranty Corporation;

(99) **Permit** means each license, provider number, permit, right, franchise, concession, certificate, authorization, consent, waiver, certificate of waiver, certificate of need, certificate of exemption, accreditation and registration, or other approval of a Governmental Authority owned or held by Seller or its Wholly Owned Subsidiaries relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(100) **Permitted Encumbrances** means those Encumbrances described on Schedule 3.11(a) as being Permitted Encumbrances;

(101) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(102) **Physician Recruitment Expenditures** means the costs related to the development and implementation of physician engagement strategies, including the costs related to sourcing and screening candidates, entering into and executing the terms of an agreement(s) to relocate a physician, including costs incurred in acquiring such physicians practice or assets, and any other similar expenditures relating to physician recruitment;

(103) **PMH** is defined in the preamble;

(104) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(105) **Purchase Price** is defined in Section 2.05;

(106) **Purchase Price Adjustment** is defined in Section 2.05(g);

(107) **RCRA** is defined in Section 3.12;

(108) **Real Property** means the Owned Real Property and the Leased Real Property;

(109) **Restricted Area** is defined in Section 6.03;

(110) **Revenue Procedure** is defined in Section 5.03(b);

(111) **Schedules** means the schedules referred to in this Agreement and attached hereto at the time that this Agreement is executed by each original party hereto;

(112) **Second 20-Day Period** is defined in Section 2.05(f);

(113) **Seller** is defined in the preamble;

(114) **Seller Deductible** is defined in Section 10.02;

(115) **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Affiliates, and, for all of them, their respective members, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(116) **Settlement Agreement** is defined in Section 2.05(f);

(117) **Special Employee Liabilities** means (i) all paid time off accruals (including vacation, holiday, and sick time benefits) of the Seller's or any Wholly Owned Subsidiary's employees, and (ii) all payments accrued as of the Closing under the Seller's or any Wholly Owned Subsidiary's long term retention payment program, culminating in **[2017]**, but in each case only to the extent there is a recorded financial obligation for Seller or its Wholly Owned Subsidiary associated with such liabilities and such recorded financial obligation is not included in the calculation of Net Working Capital;

(118) **State Health Agency** is defined in Section 3.15;

(119) **Surveys** is defined in Section 5.18;

(120) **Target Net Working Capital** means $6,800,000;

(121) **Tax** means any federal, state, local, or foreign income, unrelated business income, gross income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under Section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, employment, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, property, production, ad valorem, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, custom, duty, impost, levy or fee of any kind whatsoever, or other like assessment or charge, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(122) **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code Section 501(c)(3) organization, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(123) **Termination Fee** is defined in Section 9.04(d);

(124) **Third Party Claim** is defined in Section 10.05(a)(i);

(125) **Title Commitment** is defined in Section 5.17;

(126) **Title Company** is defined in Section 5.17;

(127) **Title Policy** is defined in Section 5.17;

(128) **Trailing EBITDA** means the normalized EBITDA of the Seller and its Wholly Owned Subsidiaries on a consolidated basis for the trailing 12-month period through the date of the most recent unaudited statements of income and cash flows of the Seller and its Wholly Owned Subsidiaries provided to Buyer pursuant to Section 5.04(b);

(129) **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*, as amended;

(130) **Transfer Act Activities** is defined in Section 5.06;

(131) **Transitional Services Agreement** means the agreement between Buyer and Seller whereby Buyer or its Affiliate will lease to Seller, at cost, employees of Seller or its Wholly Owned Subsidiaries of the Hospital Businesses who are hired by Buyer as of the Closing Date, for the orderly wind down of the benefits and administration of Seller's other post-Closing obligations (*e.g.*, finalizing Cost Reports), in substantially the form of Exhibit A attached hereto;

(132) **Unaudited Financial Statements** means the unaudited consolidated balance sheets of Seller and its Wholly Owned Subsidiaries as of [●], 2015, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the [●]-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(b);

(133) **Unfunded Pension Liabilities**[3] means the unfunded pension liabilities of Seller's or its Wholly Owned Subsidiary's defined benefit pension plan, the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan, calculated as the Accumulated Benefit Obligation reduced by the fair market value of the assets of Seller's or its Wholly Owned Subsidiary's defined benefit pension plan and of the New England Health Care Employee Pension Fund and the Connecticut Health Care Associates Pension Plan as of Closing, all as measured the actuaries currently engaged by such plans; *provided*, further, that when calculating the Accumulated Benefit Obligation for the Connecticut Health Care Associates Pension Plan, the actuary shall use a discount rate equal to seven and one-half percent (7.5%);

(134) **WARN Act** is defined in Section 3.20(e); and

(135) **Wholly Owned Subsidiary** means, with respect to any Person, (i) any corporation 100% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Wholly Owned Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Wholly Owned Subsidiaries of such Person has a 100% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Wholly Owned Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (a) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (b) whose sole member is such Person.

1.02. Certain References. As used in this Agreement:

[3] Subject to due diligence

(a) references to "*this Agreement*" mean this Agreement, as amended from time to time, and all Exhibits and Schedules attached to or referenced in this Agreement;

(b) references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Agreement, unless the context states or implies otherwise;

(c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

(d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

(e) references to "*partnerships*" include general and limited partnerships;

(f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Eastern Time;

(i) references to "*Seller's Knowledge,*" "*Knowledge of Seller,*" or words of similar intent or effect mean and refer to (x) all matters with respect to which Seller or any of its Wholly Owned Subsidiaries has received written notice, and (y) the knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02(i), after due inquiry by Seller (or Wholly Owned Subsidiary, as applicable) of such Persons;

(j) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(k) the Table of Contents, the division of this Agreement into Articles and Sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this Agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this Agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller and its Wholly Owned Subsidiaries[4] in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

[4] Subject to due diligence

(a) all Owned Real Property, including the real property described on Schedule 2.01(a);

(b) all Leased Real Property, to the extent assignable or transferrable, including the real property described on Schedule 2.01(b);

(c) all of the tangible personal property owned or leased by Seller and its Wholly Owned Subsidiaries[5] or used in the conduct of the Hospital Businesses, including all equipment (including medical and computer equipment located at the Hospital), vehicles, furniture and furnishings and other tangible personal properties, a current list and the general location of which are set forth on Schedule 2.01(c)(i); *provided* that any such leased personal property shall be described on Schedule 2.01(c)(ii);

(d) all current assets not otherwise specifically described above or below in this Section 2.01 that are included in Net Working Capital;

(e) to the extent transferable, all financial, patient, medical staff, personnel and other records of the Hospital Businesses, including, but not limited to, all documents, records, operating manuals, files, and computer software with respect to the operation of the Hospital Businesses, including, without limitation, all patient records, medical records, employee records, financial records, equipment records, construction plans and specifications, medical and administrative libraries, operating manuals, proprietary manuals, marketing materials, policy and procedure manuals, files, documents, records, books, catalogs, data, and studies or analyses;

(f) all rights and interest, to the extent assignable or transferable, with respect to the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), and the leases relating to the leased personal property listed or described on Schedule 2.01(c), and all Immaterial Contracts not listed or described on Schedule 2.02(p) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits, to the extent legally assignable, including those Permits described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and all goodwill associated therewith, and the Information Systems;

(i) all property of Seller and its Wholly Owned Subsidiaries, real, personal or mixed, tangible or intangible, arising or acquired between the date of this Agreement and the Closing Date;

(j) all usable inventories of supplies, drugs, food, janitorial and office supplies, and other disposables and consumables located at the Hospital Businesses, or

[5] Subject to due diligence

used with respect to the operation of the Hospital Businesses (the term "usable" in this clause meaning non-obsolete or slow moving and consumable within the ordinary course of business of the Hospital Businesses, consistent with past practices);

(k) all claims of Seller and its Wholly Owned Subsidiaries against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, except for those claims described on Schedule 2.02(n) and any claims relating to Excluded Assets or the Excluded Liabilities;

(l) general intangibles of the Hospital Businesses, including goodwill;

(m) all advance payments, prepayments, prepaid expenses, deposits, and the like that were made with respect to the operation of the Hospital Businesses and have continuing value to the Hospital Businesses as of the Closing Date, the current categories and amounts of which are set forth on Schedule 2.01(m);

(n) Seller's and its Wholly Owned Subsidiaries' provider agreements with third-party payors, including, but not limited to, Government Payment Programs;

(o) the electronic funds transfer account of the Hospital Businesses (the "**EFT Account**") (other than any cash in such EFT Account at Closing, which shall be an Excluded Asset) and all information necessary to access the EFT Account;

(p) all other bank accounts that receive deposits from Government Payment Programs; *provided, however*, that all funds in such accounts as of the Closing Date shall be retained by Seller;

(q) all of Seller's stock, partnership, membership, or other ownership interests, to the extent assignable or transferable and not inconsistent with Legal Requirements, in each of the Joint Ventures and Converted Ventures (the "**JV Interests**"), but only to the extent that the governing instruments thereof and Legal Requirements permit such transfer, together with all minutes and other records relating to such entities that are in the possession of Seller as of the Closing Date;

(r) to the extent assignable by Seller, all warranties (express or implied) and rights and claims assertable by (but not against) Seller and its Wholly Owned Subsidiaries related to the Assets;

(s) all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or its Wholly Owned Subsidiaries or payable to Seller or its Wholly Owned Subsidiaries, and all deductibles, copayments and self-insurance requirements payable by Seller or its Wholly Owned Subsidiaries) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(t) all other property, other than the Excluded Assets, of every kind, character, or description owned by Seller or its Wholly Owned Subsidiaries, whether

or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other businesses and ventures owned by Seller or its Wholly Owned Subsidiaries; and

(u) all proceeds of the foregoing.

Seller shall convey good and marketable title to the Assets and all parts thereof to Buyer, free and clear of all claims, assessments, security interests, liens, restrictions, and encumbrances, other than the Permitted Encumbrances and the Assumed Liabilities.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in Section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this Agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

(a) all cash, cash equivalents, and short-term and long-term Investments, including cash in the EFT Account as of the Closing Date, but, for the avoidance of doubt, excluding the JV Interests transferred pursuant to Section 2.01;

(b) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and investments restricted as to use), trusts related to employee benefits, amounts reserved in connection with any unfunded Employee Benefit Plans listed in Section 3.21 that do not have a trust, trusts related to self-insurance, donor-restricted assets, beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(c) all intercompany receivables of Seller with any of its Affiliates or Wholly Owned Subsidiaries;

(d) all other current financial assets not included in Net Working Capital;

(e) [any asset that would revert to the employer upon the termination of any of the Employee Benefit Plans, including assets representing a surplus or overfunding of any such plans][6];

(f) all rights to refunds, credits, deposits, prepayments, or the equivalent owing to Seller from any taxing authority with respect to periods prior to the Closing Date, and the right to pursue appeals of same;

(g) the taxpayer and other identification numbers, seals, minute books, corporate records, and other documents relating to the organization, maintenance, and existence of Seller and its Wholly Owned Subsidiaries;

[6] Subject to due diligence

(h) all claims, rights, interests, and proceeds (whether received in cash or by credit to amounts otherwise due to a third party) with respect to amounts overpaid with respect to the Hospital Businesses to any third party with respect to periods prior to the Closing Date;

(i) all bank accounts relating to the Hospital Businesses, other than the EFT Account and any other account that receives payments from Government Payment Programs;

(j) all writings and other items that are protected from discovery by the attorney-client privilege, the attorney work product doctrine, or any other cognizable privilege or protection of Seller or its Wholly Owned Subsidiaries;

(k) any Cost Report settlement receivables of Seller or its Wholly Owned Subsidiaries for periods ended on or prior to the Closing Date;

(l) any assets owned and provided by vendors of goods or services to the Hospital Businesses, possession of which will be retained by the Hospital Businesses;

(m) unclaimed property of any third party in respect of the operation of the Hospital Businesses, including, without limitation, property that is subject to applicable escheat laws;

(n) all rights, claims, and choses in action of Seller against third parties in respect of the operation of the Hospital Businesses with respect to periods prior to the Closing Date described on Schedule 2.2(n), and any payments, awards, or other proceeds resulting therefrom;

(o) all interests in, and assets related to, Children's Center of Greater Waterbury Health Network, Inc. and Healthcare Alliance Insurance Company, Ltd.;

(p) the name "Waterbury Hospital Foundation";

(q) all rights and interests of Seller in and to the commitments, contracts, leases, and agreements other than the Assumed Contracts, including the commitments, contracts, leases and agreements set forth on Schedule 2.02(p) (collectively, the "**Excluded Contracts**");

(r) [all physician loans and receivables][7];

(s) all insurance proceeds with respect to the Assets (including insurance proceeds received by Seller or its Wholly Owned Subsidiary or payable to Seller or its Wholly Owned Subsidiary) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent all damage to the Assets has been repaired by Seller;

[7] Subject to due diligence

(t) the portions of inventory, prepaid expenses and the like, and other Assets disposed of, expended, or canceled, as the case may be, by the Hospital Businesses prior to the Closing Date in the ordinary course of business; and

(u) any other assets identified in Schedule 2.2(t).

2.03. Assumed Liabilities. In connection with the conveyance of the Assets to Buyer, Buyer shall assume, effective as of the Closing Date, the future payment and performance of the following liabilities (the "**Assumed Liabilities**") of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses:

(a) all obligations accruing after the Closing Date with respect to the Assumed Contracts or the Leased Personal Property;

(b) the trade accounts payable and current liabilities of the Hospital Businesses as of the Closing Date, but only to the extent such accounts payable and current liabilities are included in the calculation of Net Working Capital;

(c) obligations and liabilities as of the Closing Date in respect of accrued paid time off benefits of employees of Seller or its Wholly Owned Subsidiaries of the Hospital Businesses who are hired by Buyer as of the Closing Date, and related Taxes, but only to the extent such accrued paid time off benefits, and related taxes, are included in Net Working Capital;

(d) the Capital Lease Obligations;

(e) Tax liabilities or obligations in respect of the Hospital Businesses and the Assets with respect to periods commencing on or after the Closing Date;

(f) the Asbestos Abatement Liability;

(g) any liability owed or due and owing with respect to periods on or after the Closing Date with respect to any Employee Benefit Plan listed on Schedule 2.03(g); and

(h) claims or potential claims for medical malpractice or general liability relating to events that occurred or arose prior to the Closing Date, but which are made or asserted against any of the Hospital Businesses, Joint Ventures, or Converted Ventures for the first time after the Closing Date and where such claim (or the circumstances' surrounding such claim) could not have been properly reported by such Hospital Businesses, Joint Ventures, or Converted Ventures to their respective insurance carrier(s) on or prior to the Closing Date.

Buyer shall not be liable for (i) any claims arising from Seller's or its Wholly Owned Subsidiaries' assignment and Buyer's assumption of the Assumed Liabilities; (ii) uncured defaults in the performance of the Assumed Liabilities for periods prior to the Closing Date; (iii) unpaid amounts in respect of the Assumed Liabilities that are due as of the Closing Date (that are not reflected in Net Working Capital or the Capital Lease Obligations); and/or (iv) rights or

remedies claimed by third parties under any of the Assumed Liabilities that broaden or vary the rights and remedies such third parties would have had against Seller, its Wholly Owned Subsidiaries and the Hospital Businesses if the sale and purchase of the Assets were not to occur.

2.04. Excluded Liabilities. Except for the Assumed Liabilities, the Buyer shall not assume and under no circumstances shall the Buyer be obligated to pay or assume, and none of the assets of Buyer shall be or become liable for or subject to, any liability, indebtedness, commitment, or obligation of Seller or its Wholly Owned Subsidiaries, whether known or unknown, fixed or contingent, recorded or unrecorded, currently existing or hereafter arising or otherwise (collectively, the "**Excluded Liabilities**"), including, without limitation, the following Excluded Liabilities:

(a) any debt, obligation, expense, or liability that is not an Assumed Liability;

(b) claims or potential claims for medical malpractice or general liability relating to events that occurred or arose prior to the Closing Date, but which are made or asserted against any of the Hospital Businesses, Joint Ventures, or Converted Ventures for the first time prior to the Closing Date, and any such claim made or asserted before or after the Closing Date, where such claim (or the circumstances surrounding such claim) could have properly been reported by such Hospital Businesses, Joint Ventures, or Converted Ventures to their respective insurance carrier(s) on or prior to the Closing Date;

(c) those claims and obligations (if any) specified in Schedule 2.04 hereto;

(d) any liabilities or obligations associated with or arising out of any of the Excluded Assets;

(e) liabilities or obligations associated with indebtedness for borrowed money (other than Capital Lease Obligations);

(f) liabilities and obligations of Seller or its Wholly Owned Subsidiaries in respect of the Hospital Businesses with respect to periods prior to the Closing Date arising under the terms of Government Payment Programs or other third party payor programs, and any liability arising pursuant to Government Payment Programs or other third party payor programs as a result of the consummation of any of the transactions contemplated under this Agreement, including, for the avoidance of doubt, all Medicare and Medicaid Cost Reports, DSH payments or other settlements for all periods prior to the Closing Date;

(g) Taxes incurred by the Hospital Businesses with respect to periods prior to the Closing Date (*provided, however*, that this clause (g) shall not apply to any and all Taxes payable with respect to any employee benefits constituting Assumed Liabilities under Section 2.03(c) hereof and any Taxes constituting Assumed Liabilities under Section 2.03(e) hereof);

(h) liability for any and all claims by or on behalf of employees of Seller or its Wholly Owned Subsidiaries relating to periods prior to the Closing Date, including,

without limitation, liability for any pension, profit sharing, deferred compensation, or any other employee health and welfare benefit plans, liability for any Equal Employment Opportunity Commission claim, Americans with Disability Act claim, Family and Medical Leave Act claim, wage and hour claim, unemployment compensation claim, or workers' compensation claim, and any liabilities or obligations to former employees of Seller or its Wholly Owned Subsidiaries under COBRA (*provided, however*, that this clause (i) shall not apply to any and all employee benefits constituting Assumed Liabilities under Section 2.03(g) hereof);[8]

(i) any obligation or liability accruing, arising out of, or relating to any federal, state, or local investigations of, or claims or actions against, Seller or its Wholly Owned Subsidiaries, the Hospital Businesses, or any of their employees, medical staff, agents, vendors, or representatives with respect to acts or omissions prior to the Closing Date;

(j) any civil or criminal obligation or liability accruing, arising out of, or relating to any acts or omissions of Seller, its Wholly Owned Subsidiaries, or their directors, officers, employees, representatives, and agents claimed to violate any Legal Requirements of any Governmental Authority arising out of acts occurring before the Closing Date;

(k) liabilities or obligations arising as a result of any breach by Seller or its Wholly Owned Subsidiaries or the Hospital Businesses at any time of any Excluded Contract;

(l) liabilities or obligations arising out of any breach by Seller or its Wholly Owned Subsidiaries or the Faclities prior to the Closing Date of any Assumed Contract;

(m) any obligation or liability asserted under the federal Hill-Burton Act or other restricted grant and loan programs with respect to the ownership or operation of the Hospital Businesses or the Assets;

(n) any debt, obligation, expense, or liability of Seller or its Wholly Owned Subsidiaries arising out of or incurred solely as a result of any transaction occurring after the Closing Date or for any violation by Seller or its Wholly Owned Subsidiaries of any law, regulation, or ordinance at any time (including, without limitation, those pertaining to fraud, environmental, health care regulatory, and ERISA matters);

(o) all liabilities and obligations relating to any oral agreements, oral contracts, or oral understandings, including those with any referral sources, including, but not limited to, physicians, unless reduced to writing and expressly assumed as part of the Assumed Contracts;

(p) any liability arising out of the act of assignment of any of the Assumed Contracts to Buyer at the Closing;

[8] Subject to due diligence

(q) the obligations and liabilities arising in connection with Transfer Act; and

(r) all workers' compensation liabilities of Seller and its Wholly Owned Subsidiaries.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and its Wholly Owned Subsidiaries and tender the purchase price, determined as follows (the "**Purchase Price**"), subject to the adjustments described in Section 2.05(g):

(i) $31,800,000, *plus*

(ii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds the Target Net Working Capital, or *minus*

(iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than the Target Net Working Capital, and *minus*

(iv) the amount of the Capitalized Lease Obligations in excess of $6,500,000, and *minus*

(v) the Unfunded Pension Liabilities, which shall be calculated as of the Closing Date, and *minus*

(vi) the Asbestos Abatement Liability, and *minus*

(vii) the amount of liabilities listed on Schedule 2.05(a)(vii).[9]

(b) Notwithstanding the foregoing Section 2.05(a), no liabilities of Seller or its Wholly Owned Subsidiaries shall be subtracted from the Purchase Price to the extent any such liabilities are already included in Net Working Capital.

(c) The Purchase Price, including estimates at Closing of the Net Working Capital and the Unfunded Pension Liabilities, will be calculated as follows.

(i) For purposes of determining the Purchase Price, not more than five (5) but in no event less than two (2) business days prior to the Closing, Seller shall deliver to Buyer a statement setting forth its good faith estimate as of the Closing Date of the (a) Net Working Capital and (b) Unfunded Pension Liabilities, including supporting documentation of reasonable specificity and other information requested by the Buyer to verify such amounts.

[9] TBD based on due diligence – may be "none"

(ii) The estimate of Net Working Capital at Closing will be calculated by Seller from the physical count of Seller's inventory for its September 30, 2015 audit and its ensuing customary perpetual inventory, the relevant entries in the Interim Closing Balance Sheets and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06. The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on Seller's perpetual inventory system and valued in Seller's customary manner. The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer.

(iii) The estimate of Unfunded Pension Liabilities at Closing will be calculated by Seller from the Interim Closing Balance Sheets and/or the then most recently updated actuarial analyses.

(d) At Closing, Buyer shall pay such Purchase Price (based on the estimate provided by Seller pursuant to Section 2.05(c)) by wire transfer of immediately available funds to an account designated by the Seller to Buyer prior to the Closing Date, and Seller shall immediately use whatever portion of the Purchase Price is necessary to pay off all indebtedness of Seller (other than Capitalized Lease Obligations assumed by Buyer), including the indebtedness under the Loan Agreement.

(e) Not more than ninety (90) days after the Closing, Buyer shall prepare and deliver, or cause to be prepared and delivered, to Seller, the final closing statement (the "**Final Closing Statement**") setting forth (i) its good faith determination of the actual Net Working Capital as of the Closing Date (based on the Closing Balance Sheets), (ii) a calculation showing the difference between the Net Working Capital estimated by Seller at Closing and the actual Net Working Capital as of the Closing Date, (iii) its good faith determination of the actual Unfunded Pension Liabilities as of the Closing Date (as determined by the actuaries then serving those pension plans), and (iv) a calculation showing the difference between the Unfunded Pension Liabilities estimated by Seller at Closing and the actual Unfunded Pension Liabilities (as determined by the actuaries then serving those pension plans) as of the Closing Date. Except as otherwise provided herein, the Final Closing Statement and the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable, Unfunded Pension Liabilities, contractual allowances and doubtful accounts, as used in preparing the Audited Financial Statements, except as otherwise provided in this Agreement.

(f) Following receipt of the information set forth in Section 2.05(e), Seller will be afforded a period of twenty (20) business days (the "**20-Day Period**") to review the Final Closing Statement and the Closing Balance Sheets. At or before the end of the 20-Day Period, Seller will either (i) accept the amount of the actual Net Working Capital and Unfunded Pension Liabilities calculated by Buyer in their entirety or (ii) deliver to Buyer a written notice (the "**Objection Notice**") containing a reasonably detailed written explanation of those items on the Final Closing Statement or the Closing Balance Sheets that Seller disputes, in which case the items specifically identified by Seller shall be

deemed to be in dispute. The failure by Seller to deliver the Objection Notice within the 20-Day Period shall constitute Seller's acceptance of the amount of the actual Net Working Capital and Unfunded Pension Liabilities calculated by Buyer. If Seller delivers the Objection Notice in a timely manner, then, within a further period of twenty (20) business days from the end of the 20-Day Period (the "**Second 20-Day Period**"), the parties will attempt to resolve in good faith any disputed items and reach a written agreement (the "**Settlement Agreement**") with respect thereto. Failing such resolution, as promptly as practicable (and no event later than ten (10) business days from the end of the Second 20-Day Period), the unresolved disputed items will be referred for final binding resolution to Deloitte (the "**Arbitrating Accountants**"). In resolving any disputed item, the Arbitrating Accountants may not assign a value to any item greater than the greatest value for such item claimed by either party or less than the smallest value for such item claimed by either party. The fees and expenses of the Arbitrating Accountants shall be allocated between Buyer and Seller in proportion to the amounts by which their proposals of the actual Net Working Capital and Unfunded Pension Liabilities differed from the Arbitrating Accountants' final determination. Such determination (the "**Accountants' Determination**") shall be (i) in writing, (ii) furnished to the Buyer and Seller as soon as practicable (and in no event later than thirty (30) business days) after the items in dispute have been referred to the Arbitrating Accountants, (iii) made in accordance with GAAP, consistently applied, and (iv) non-appealable and incontestable by Buyer or Seller and each of their respective Affiliates and successors and assigns and not subject to collateral attack for any reason other than manifest error or fraud.

(g) The Purchase Price will be recalculated (based on clauses (i), (ii) and (iii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(c)(ii) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) estimated at Closing and the actual Net Working Capital as of the Closing Date (based on the Closing Balance Sheets), and (iii) the difference between the Unfunded Pension Liabilities estimated at Closing and the actual Unfunded Pension Liabilities (based on the Closing Balance Sheets).

(h) Within five (5) business days following the Final Determination Date, Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay the Seller (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient. In the event that Seller is required to pay Buyer pursuant to this Section 2.05(h), and payment is not made in full by Seller within five (5) business days following the Final Determination Date, Buyer shall be entitled, but shall not be obligated, to apply an amount equal to the shortfall in such payment against the Indemnification Holdback Amount, in accordance with Section 10.09(a).

2.06. Prorations. At Closing, and to the extent not included in Net Working Capital, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Person that is a non-profit corporation that does not pay any property Taxes with respect to such property) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer upon Buyer's receipt of such credit.

2.07. Disclaimer of Warranties. Subject to the representations and warranties set forth in this Agreement, including, but not limited to, those set forth in Article 3, and except as expressly set forth in the Closing Documents, the Assets transferred to the Company and any Buyer will be transferred in their physical condition at the Effective Time, "AS IS, WHERE IS, AND WITH ALL FAULTS AND NONCOMPLIANCE WITH LAWS," and with respect to the Real Property, land, buildings, and improvements, WITH NO WARRANTY OF HABITABILITY OR FITNESS FOR HABITATION, and with respect to the physical condition of the personal property and the inventory and supplies, WITH NO WARRANTIES, INCLUDING, WITHOUT LIMITATION, THE WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer and PMH on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Seller is a non-stock corporation duly organized and validly existing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct the Hospital Businesses as now being conducted, to enter into this Agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this Agreement and the Closing Documents to which Seller is or becomes a party, and the consummation by Seller of the transactions contemplated by this Agreement:

(a) are within its corporate powers, are not in contravention of law or of the terms of its organizational documents, and have been duly authorized by all appropriate corporate action;

(b) except as provided in Section 5.05 below, do not require any approval or consent of, or filing with, any Governmental Authority bearing on the validity of this

Agreement that is required by Legal Requirements of any such Governmental Authority;

(c) except as set forth in Schedule 3.02(c), will neither conflict with, nor result in any breach or contravention of, or the creation of any lien, charge, or encumbrance under, or permit the acceleration of the maturity of, any indenture, agreement, lease, instrument, or understanding to which it is a party or by which it is bound, except for such breaches or contraventions that may result from the failure to obtain the consent of the counterparty thereto in connection with the assignment of any Assumed Contract to the Buyer and for which Seller remains liable;

(d) will not violate any material Legal Requirements of any Governmental Authority to which it or the Assets may be subject; and

(e) will not violate any judgment, decree, writ, or injunction of any court or Governmental Authority to which it or the Assets may be subject.

3.03. Binding Agreement. This Agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof.

3.04. Investments and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material assets, or any interest therein, of Seller, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Buyer with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance.

(a) Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.05(a) or as set forth on Schedule 3.05(a), the operations of the Hospital Businesses are in compliance in all material respects with all applicable Legal Requirements of Governmental Authorities having jurisdiction over the Hospital Businesses and the operations of the Hospital or its related ancillary services. Seller and its Wholly Owned Subsidiaries have timely filed all reports, data, and other information required to be filed with any Governmental Authorities. Neither Seller nor its Wholly Owned Subsidiaries, nor any of its officers, directors, agents, or employees thereof, has committed a violation of federal or state laws regulating health care fraud, including but not limited to the federal Anti-Kickback Law, 42 U.S.C. §1320a-7b, the Stark Laws, 42 U.S.C. §1395nn, as amended, and the False Claims Act, 31 U.S.C. §3729, et seq. Seller and its Wholly Owned Subsidiaries are in compliance in all material respects with the administrative simplification provisions required under HIPAA, including the electronic data interchange regulations and the health care privacy

regulations. Seller and its Wholly Owned Subsidiaries have not received notice of any claim, Proceeding, or investigation alleging or based upon an alleged material violation of any Legal Requirements.

(b) Seller has provided to Buyer a copy of the Hospital's current compliance program materials, including, without limitation, all program descriptions, compliance officer and committee descriptions, ethics and risk area policy materials, training and education materials, auditing and monitoring protocols, reporting mechanisms, and disciplinary policies. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.05(b) or to the extent set forth on Schedule 3.05(b), Seller (or any Wholly Owned Subsidiary thereof) (a) is not a party to a Corporate Integrity Agreement with the Office of Inspector General of the United States Department of Health and Human Services, (b) has no reporting or other continuing obligations pursuant to any settlement or other agreement entered into with any Government Authority (other than participation agreements with Government Payment Programs), (c) to the Knowledge of Seller, has not been the subject of any Government Payment Program investigation conducted by any federal or state enforcement agency within the past three (3) years, (d) has not been a defendant in any unsealed *qui tam*/False Claims Act litigation within the past three (3) years, (e) has not been served with or received, within the past three (3) years, any search warrant, subpoena, civil investigative demand, or contact letter by or from any Government Authority (except in connection with medical services provided to third parties who may be defendants or the subject of investigation into conduct unrelated to the operations of the health care businesses conducted by the Hospital Businesses), and (f) has not received any complaints within the past three (3) years from employees, independent contractors, vendors, physicians, or any other person that would indicate that Seller (or any Wholly Owned Subsidiary thereof) has violated any Legal Requirements. Schedule 3.05(b) includes a description of each audit and investigation conducted by Seller at the Hospital pursuant to its compliance program during the past three (3) years. For purposes of this Agreement, the term "compliance program" refers to provider programs of the type described in the compliance guidance published by the Office of Inspector General of the Department of Health and Human Services.

3.06. Financial Statements; Undisclosed Liabilities. Seller has delivered to Buyer copies of the following financial statements (collectively, the "**Financial Statements**"), which Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 3.06:

(a) Unaudited balance sheet dated as of _____, 2015 (the "**Balance Sheet Date**");

(b) Unaudited income statement for the _____-month period ended on the Balance Sheet Date; and

(c) Audited Financial Statements.

Such unaudited Financial Statements conform to GAAP consistently applied, except as set forth on Schedule 3.06. Such audited Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such balance sheets present fairly the financial condition of Seller as of the dates indicated thereon, and such income statements included in the Financial Statements present fairly the results of operations of Seller for the periods indicated thereon. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses, Joint Ventures or Converted Ventures, or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in Financial Statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the Balance Sheet Date, and none of which could reasonably be expected to result, individually or in the aggregate, in a material adverse effect.

3.07. Recent Activities. Except as set forth in Schedule 3.07, with respect to Seller or its Wholly Owned Subsidiaries, since the Balance Sheet Date there has not been any:

(a) material damage, destruction, or loss (whether or not covered by insurance) affecting the Hospital Businesses or the Assets;

(b) material adverse change in the condition, financial or otherwise, of the Hospital Businesses or the Assets, including, but not limited to, the business or prospects of the Hospital Businesses or the results of operations of the Hospital Businesses;

(c) threatened employee strike, material work stoppage, or material labor dispute pertaining to the Hospital Businesses;

(d) sale, assignment, transfer, or disposition of any item of property, plant, or equipment included in the Assets and having a net book value in excess of Seventy-Five Thousand Dollars ($75,000) (other than supplies), except in the ordinary course of business with comparable replacement thereof;

(e) sale, factor or disposition of, or agreement to sell, factor or dispose of, any accounts receivable;

(f) any general increase in the compensation payable to any of its or their employees or independent contractors or any increase in, or institution of, any bonus, severance, insurance, pension, profit-sharing or other employee benefit plan, remuneration, or arrangements made to, for, or with such employees;

(g) dividend, distribution, or extraordinary payment;

(h) change in the composition of the medical staff of the Hospital Businesses, other than normal turnover occurring in the ordinary course of business;

(i) change in the rates charged by the Hospital Businesses for their services, other than those made in the ordinary course of business;

(j) adjustment or write-off of accounts receivable or reduction in reserves for accounts receivable outside the ordinary course of business;

(k) change in the accounting methods or practices, including the methods used to estimate contractual allowances or doubtful accounts, other than those required by any changes in GAAP, or change in depreciation or amortization policies;

(l) encumbrance or lien that has been imposed on any of the Assets;

(m) cancellation or waiver of any material rights in respect of the Assets, except in the ordinary course of business;

(n) other than compensation paid in the ordinary course of employment, sale of any Assets to, or execution of any contract or agreement with, any officer, director or trustee of Seller, or with any Affiliate of any such person or entity;

(o) payment or agreement to pay to any Person any damages, fines, penalties or other amounts in excess of $25,000 individually or $100,000 in the aggregate in respect of an actual or alleged violation of any Legal Requirement; or

(p) transaction outside the ordinary course of business.

3.08. Accounts Receivable; Inventory.

(a) All Accounts Receivable constituting a part of the Assets represent and constitute bona fide indebtedness owing to Seller (or any Wholly Owned Subsidiary thereof) for services actually performed or for goods or supplies actually provided in the amounts indicated on the Financial Statements with no known Encumbrances, set-offs, deductions, compromises, or reductions (other than reasonable allowances for bad debts and contractual allowances in an amount consistent with historical policies and procedures of Seller and that are taken into consideration in the preparation of the Financial Statements). Seller has made available to Buyer a complete and accurate aging report of all such Accounts Receivable and a schedule of all Accounts Receivable that have been assigned to collection agencies or are otherwise held or assigned for collection.

(b) The inventory and supplies constituting part of the Assets are substantially of a quality and quantity usable and salable in the ordinary course of business of the Hospital Businesses. Obsolete items have been written off the Financial Statements. Inventory and supplies are carried at cost, on a first-in, first-out basis, and are properly stated in the Financial Statements in accordance with GAAP. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.09. Equipment. Seller has delivered to Buyer a fixed asset listing and depreciation schedule as of the Balance Sheet Date (Schedule 3.09) that takes into consideration all the equipment associated with, or constituting any part of, the Hospital Businesses and the Assets.

All major items of equipment are useable for their intended purpose in the ordinary course of business and are in working condition, subject to reasonable wear and tear.

3.10. Title. Except as provided in Schedule 3.10, Seller or its Wholly Owned Subsidiary, as applicable, owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Permitted Encumbrances and Assumed Liabilities.

3.11. Real Property.

(a) Seller or its Wholly Owned Subsidiary, as applicable, owns good and marketable fee simple and/or leasehold title, as the case may be, to the Real Property, together with all buildings, improvements, and component parts thereon and all appurtenances and rights thereto. The Real Property will be conveyed to the Buyer free and clear of any and all Encumbrances other than the Permitted Encumbrances set forth on Schedule 3.11(a).

(b) With respect to the Real Property, except as set forth in Schedule 3.11(b):

(i) Neither Seller nor any Wholly Owned Subsidiary has received during the past five (5) years written notice of a violation of any applicable Legal Requirement;

(ii) The Owned Real Property, and, to Seller's Knowledge, Leased Real Property, and its operation are in compliance in all material respects with all applicable zoning ordinances, and the consummation of the transactions contemplated herein will not result in a violation of any applicable zoning ordinance or the termination of any applicable zoning variance now existing, and the buildings and improvements constituting the Real Property comply in all material respects with all building codes;

(iii) The Owned Real Property and, to Seller's Knowledge, Leased Real Property, is subject to no easements, restrictions, ordinances, or other limitations on title that could make such property unusable for its current use or the title uninsurable or unmarketable or that materially restrict or impair the use, marketability, or insurability of the Real Property other than the Permitted Encumbrances;

(iv) All of the Owned Real Property, and, to Seller's Knowledge, Leased Real Property, currently in use for the operations of the Hospital Businesses is in compliance in all material respects with the applicable provisions of the Rehabilitation Act of 1973, Title III of the Americans with Disabilities Act, and the provisions of any comparable state statute relative to accessibility (these laws are referred to, collectively, as the "**Accessibility Laws**"), and there is no pending, noticed, or, to the Knowledge of Seller, threatened litigation, administrative action, or complaint (whether from a state, federal, or local government or from any other person, group, or entity) relating to compliance of any of the Real Property with the Accessibility Laws;

(v) There are no tenants or other persons or entities occupying any space in the Owned Real Property other than pursuant to tenant leases described in Schedule 3.11(b), and no tenants have paid rent in advance for more than one month and no rebate, concession, improvement credit or other tenant allowance of any nature is owed to any tenant, nor is any landlord improvement work required, except as disclosed in Schedule 3.11(b);

(vi) All material obligations of Seller or any Wholly Owned Subsidiary as landlord required to be performed under each of the tenant leases have been performed;

(vii) Attached to Schedule 3.11(b) is a "rent roll" that sets forth for those leases where Seller or any Wholly Owned Subsidiary in respect of the Hospital Businesses is landlord, which contains: (i) the names of then current tenants; (ii) the rental payments for the then current month under each of the leases; (iii) a list of all then delinquent rental payments; (iv) a list of all concessions granted to tenants; (v) a list of all tenant deposits and a description of any application thereof, and (vi) a list of all uncured material defaults under the leases known to Seller or its Wholly Owned Subsidiaries;

(viii) Seller or any Wholly Owned Subsidiary has not received written notice of condemnation or of any special assessment relating to any part of the Real Property, of any existing or proposed plans to modify or realign any street or highway, or any existing or proposed eminent domain proceeding by any Government Authority that would result in the taking of all or any part of the Real Property or that would adversely affect the current use of any part of the Real Property;

(ix) All permanent certificates of occupancy and all other material licenses, permits, authorizations, consents, certificates, and approvals required by all Government Authorities having jurisdiction and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions) have been issued for the Owned Real Property (and all individual items constituting the Owned Real Property), for their current uses, have been paid for, are in full force and effect, and will not be invalidated, violated, or otherwise adversely affected by the transfer of the Real Property to the Buyer; and

(x) To the Knowledge of Seller, water, sanitary sewer, storm sewer, drainage, electric, telephone, gas, and other public utility systems are available to the Real Property, as currently developed, and are directly connected to the lines and/or other facilities of the respective public authorities or utility companies providing such services or accepting such discharge, either adjacent to the Real Property or through easements or rights of way appurtenant to and forming a party of the Real Property; and, with respect to the Owned Real Property, to the Knowledge of Seller, such easements or rights-of-way have been fully granted, all charges therefor have been fully paid by Seller or its Wholly Owned Subsidiaries, and all charges for the aforesaid utility systems and the connection of the Owned

Real Property to such systems, including without limitation connections fees, "tie-in" charges, and other charges now or hereafter to become due and payable, have been fully paid by Seller or its Wholly Owned Subsidiaries; and the water and sanitary sewer service described above is supplied by public authority.

3.12. Environmental Laws. Except as set forth on Schedule 3.12 hereto, (i) the Owned Real Property is not subject to any material environmental hazards, risks, or liabilities, (ii) neither Seller or its Affiliates, nor its Wholly Owned Subsidiaries, is in material violation of any and all Legal Requirements pertaining to the protection of human health and safety or the environment (collectively, "**Environmental Laws**"), including, without limitation, the Comprehensive Environmental Response Compensation and Liability Act, as amended ("**CERCLA**"), the Resource Conservation and Recovery Act, as amended ("**RCRA**"), and the Atomic Energy Act of 1954, as amended ("**AEA**"), and (iii) neither Seller nor any Affiliate thereof has received notice alleging or asserting either a violation of any Environmental Law or an obligation to investigate, assess, remove, or remediate any property, including but not limited to the Owned Real Property, under or pursuant to any Environmental Law. Except as set forth on Schedule 3.12, to the Knowledge of Seller, no Hazardous Substances have been, and through the Closing Date will be, disposed of on or released or discharged from or onto, or threatened to be released from or onto, the Owned Real Property (including groundwater) by Seller, or to Seller's Knowledge, any third party, in violation of any applicable Environmental Law. Except as set forth on Schedule 3.12, neither Seller or its Wholly Owned Subsidiaries nor, to Seller's Knowledge, any prior owners, operators, or occupants of the Owned Real Property, have allowed any Hazardous Substances to be discharged, processed, or otherwise released on the Owned Real Property in a manner that is in violation of any Environmental Law, and Seller and its Wholly Owned Subsidiaries has complied in all material respects with all Environmental Laws applicable to any part of the Real Property. The Hospital Businesses contain asbestos-containing material. Schedule 3.12 lists numerous reports, correspondence, operation and maintenance manuals, and other documents related to the asbestos-containing materials. These documents do not individually or collectively constitute a comprehensive asbestos survey of the Hospital Businesses or the Owned Real Property. Without in any way limiting the generality of the foregoing, to the Knowledge of Seller: (i) all current or former underground storage tanks located on the Owned Real Property and information in Seller's possession relating to the capacity, uses, dates of installation, and contents of such tanks located on the Owned Real Property are identified in the environmental reports listed on Schedule 3.12; (ii) there are not now, nor have there ever been, any collection dumps, pits, and disposal facilities or surface impoundments located on the Owned Real Property for the containment of Hazardous Substances except as identified in Schedule 3.12; and (iii) all existing underground storage tanks have been maintained in material compliance with all Environmental Laws. Except as set forth on Schedule 3.12, Seller or its Wholly Owned Subsidiaries holds all material environmental permits required in connection with the use by Seller of the Real Property or the operation of the Hospital Businesses and, to the extent permitted by law, Seller shall cause such environmental permits to be transferred to the Buyer (with the Buyer's necessary cooperation and assistance), all of which, to Seller's Knowledge, are in good standing and are not subject to meritorious challenge. The representations and warranties made in this Section 3.12 are the exclusive representations and warranties of Seller relating to environmental matters and shall supersede any and all other Sections in this Agreement including, but not limited to, Sections 3.05, 3.11(a) and 3.15.

3.13. Intellectual Property; Information Systems. Schedule 3.13 lists and briefly describes all material Intellectual Properties currently owned or used by Seller or its Wholly Owned Subsidiaries. No proceedings have been instituted or are pending or, to the Knowledge of Seller, threatened that challenge the validity of the ownership or use by Seller or its Wholly Owned Subsidiaries of such Intellectual Properties. Neither Seller nor its Wholly Owned Subsidiaries have agreed to license to a third party any owned Intellectual Properties and have no Knowledge of the use or the infringement of any such owned Intellectual Properties by any other Person. Seller (or any Wholly Owned Subsidiary thereof) owns (or possesses adequate and enforceable licenses or other rights to use) all material Intellectual Properties and all material Information Systems used.

3.14. Insurance. Schedule 3.14 is an accurate schedule of the insurance policies or self-insurance funds maintained by Seller or its Wholly Owned Subsidiaries covering the ownership and operations of the Hospital Businesses and the Assets, including the type of insurance, policy numbers, identity of insurers, amounts, and coverage. Seller has provided to Buyer a copy of all such policies and endorsements thereto. All of such policies are in full force and effect with no premium arrearage. Seller or its Wholly Owned Subsidiary, or any Affiliates thereof, has given in a timely manner to its insurers all notices required to be given under its insurance policies with respect to all of the claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions. Seller and its Wholly Owned Subsidiaries have not (a) received any written notice or other communication from any such insurance company canceling or materially amending any of such insurance policies, and to the Knowledge of Seller, no such cancellation or amendment is threatened, or (b) failed to give any required notice or present any claim that is still outstanding under any of such policies with respect to the Hospital Businesses or any of the Assets.

3.15. Permits. Each of the Hospital Businesses is duly licensed pursuant to the applicable laws of the State of Connecticut. The pharmacies, laboratories, and all other ancillary departments located at the Hospital Businesses or operated for the benefit of the Hospital Businesses that are required to be specially licensed are duly licensed by the Connecticut Department of Public Health or other appropriate licensing agency (the "**State Health Agency**"). Seller and its Wholly Owned Subsidiaries have all material Permits that are needed or required by law to operate the business related to or affecting the Hospital Businesses or any ancillary services related thereto. Seller has delivered to Buyer an accurate list and summary description (Schedule 2.01(g)) of all such Permits owned or held by Seller or its Wholly Owned Subsidiaries relating to the ownership, development, or operation of the Hospital Businesses or the Assets, all of which are now and as of the Closing shall be in good standing, except as disclosed on Schedule 3.15. Seller and its Wholly Owned Subsidiaries have not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any Permits relating to the Hospital Businesses or any ancillary services related thereto.

3.16. Government Payment Programs; Accreditation; Payor Cost Reports.

(a) The Hospital is qualified for participation in the Government Payment Programs, has a current and valid provider contract with such programs, is in compliance with the conditions of participation in such programs, and has received all

approvals or qualifications necessary for reimbursement for the Hospital. The Hospital is duly accredited, with no contingencies, by The Joint Commission (the "**Joint Commission**") for the three (3) year period set forth on Schedule 3.16(a). A copy of the most recent accreditation letter from the Joint Commission pertaining to the Hospital has been made available to Buyer. Seller has delivered to Buyer copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction since [●], 20__. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein. The billing practices employed by the Hospital Businesses with respect to all third party payors, including Government Payment Programs and private insurance companies, have been in compliance in all material respects with all applicable laws, regulations, and policies of the Government Payment Programs and applicable Contracts of such private insurance companies. Neither Seller nor its Wholly Owned Subsidiaries has billed or received any payment or reimbursement from any such payors in excess of amounts allowed by law or contract. Neither Seller nor any of its Affiliates, officers, directors, managers, employees, or controlling shareholders is excluded from participation in the Government Payment Programs, nor has Seller or any of its Wholly Owned Subsidiaries received any notice that any such exclusion is threatened. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.16 or as set forth on Schedule 3.16(a), neither Seller nor its Wholly Owned Subsidiaries has received any notice from any of the Government Payment Programs or any other third party payor programs of any pending or threatened investigations or surveys, and, to the Knowledge of Seller, no such investigations or surveys are pending, threatened, or imminent. Seller has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to the Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made in accordance with applicable reporting deadlines and in the form and manner required by CMS and the Joint Commission, respectively. Seller has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired.

(b) Seller, or its Wholly Owned Subsidiary, has duly filed all required Cost Reports in respect of the Hospital Businesses for all the fiscal years through and including the fiscal year ended September 30, 2014. All amounts shown as due from Seller (or any Wholly Owned Subsidiaries thereof) in such Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. All of such Cost Reports accurately reflect the information required to be included thereon and such Cost Reports do not claim and neither the Hospital Businesses nor Seller (or any Wholly Owned Subsidiaries thereof) has received reimbursement in any amount in excess of the amounts provided by law or

any applicable agreement. Schedule 3.16(b) indicates which of such Cost Reports have not been audited and finally settled and a brief description of any and all notices of program reimbursement, proposed or pending audit adjustments, disallowances, appeals of disallowances, and any and all other unresolved claims or disputes in respect of such Cost Reports. Seller or its Wholly Owned Subsidiary has established adequate reserves in respect of the Hospital Businesses to cover any potential reimbursement obligations that may exist in respect of any such third party Cost Reports, and such reserves are set forth in the Financial Statements.

3.17. Agreements and Commitments. Schedule 2.01(f) sets forth the Assumed Contracts that will be assumed by the Buyer. Seller has also delivered to Buyer an accurate list (Schedule 3.17) of all material Contracts that materially affect the Hospital Businesses or the Assets, to which Seller or its Wholly Owned Subsidiary is a party or by which Seller, its Wholly Owned Subsidiaries, the Assets, or any portion thereof, is bound, including, without limitation, (a) physician agreements, professional service agreements or co-management agreements, (b) agreements with health maintenance organizations, preferred provider organizations, independent practice associations, accountable care organizations, or other alternative delivery systems, (c) joint venture or partnership agreements, (d) employment, severance or retention Contracts or any other Contracts to or with individual employees or agents, including with directors, trustees, officers, employees, or other agents of Seller or its Wholly Owned Subsidiaries, (e) Contracts materially affecting ownership of, title to, use of, or any interest in Owned Real Property or Leased Real Property, (f) equipment leases and other leases that are capital leases, (g) equipment maintenance agreements, (h) agreements with Governmental Authorities, (i) collective bargaining agreements or other Contracts to or with any labor unions, labor organizations, or other employee representatives or groups of employees, (j) loan agreements, bonds, mortgages, liens, or other security agreements, (k) Contracts relating to Intellectual Properties and Information Systems, or other like Contracts affecting the Hospital Businesses or the Assets, (l) Contracts providing for payments based in any manner on the revenues or profits of Seller or any Wholly Owned Subsidiary thereof, the Hospital Businesses or the Assets, (m) Contracts relating to data processing programs, software, or source codes utilized in connection with the Hospital Businesses or the Assets, (n) Contracts relating to the administration, operation or funding of any Employee Benefit Plan, and (o) Contracts, whether in the ordinary course of business or not, that involve future payments, performance of services, or delivery of goods or material, to or by Seller (or any of its Wholly Owned Subsidiaries), of any amount or value in excess of Fifty Thousand Dollars ($50,000) on an annual basis.

3.18. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f), Seller has made available to Buyer true and correct copies of the Assumed Contracts, and has given, and will give, the agents, employees, and representatives of Buyer access to the originals of the Assumed Contracts in its possession. Seller represents and warrants with respect to the Assumed Contracts that:

(a) The Assumed Contracts constitute valid and legally binding obligations of Seller or a Wholly Owned Subsidiary and are enforceable against Seller or such Wholly Owned Subsidiary in accordance with their terms;

(b) Each Assumed Contract constitutes the entire agreement by and between the respective parties thereto with respect to the subject matter thereof;

(c) All obligations required to be performed by Seller or its Wholly Owned Subsidiary under the terms of the Assumed Contracts have been performed, no material breach has occurred under any of the Assumed Contracts, no act or omission by Seller or its Wholly Owned Subsidiary has occurred or failed to occur that, with the giving of notice, the lapse of time, or both would constitute a material default under the Assumed Contracts, and each of such Assumed Contracts is now in full force and effect;

(d) Except as expressly set forth on Schedule 3.18, none of the Assumed Contracts requires consent to the assignment and assumption of such Contracts by Buyer;

(e) Except as expressly set forth on Schedule 3.18, the assignment of the Assumed Contracts to and assumption of such Assumed Contracts by Buyer will not result in any penalty or premium, or variation of the rights, remedies, benefits, or obligations of any party thereunder; and

(f) Except as expressly set forth on Schedule 3.18, no Assumed Contract contains a prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing.

3.19. Transactions with Affiliates. Since September 30, 2014, Seller (or any Wholly Owned Subsidiary thereof) has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller, except as set forth on Schedule 3.19 or upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.20. Employees and Employee Relations.

(a) Except as set forth on Schedule 3.20(a), all employees of the Hospital Businesses are employees of Seller or its Wholly Owned Subsidiaries, and there has not been in the last three (3) years, there is not presently pending, there is not presently threatened (to the Knowledge of Seller), and no event has occurred or circumstance exists (to the Knowledge of Seller) that could provide the basis for, (i) any strike, slowdown, picketing, work stoppage, or employee grievance process, or (ii) any proceeding against or affecting Seller or its Wholly Owned Subsidiaries relating to an alleged violation of any Legal Requirements pertaining to labor relations, including, without limitation, any charge, complaint, or unfair labor practices claim filed by an employee, union, or other person with the National Labor Relations Board or any comparable Governmental Authority, organizational activity, or other labor dispute against or affecting Seller, its Wholly Owned Subsidiaries, the Hospital Businesses, or their premises.

(b) Except as set forth in Schedule 3.20(b), with respect to the employees of Seller or its Wholly Owned Subsidiaries: (i) no collective bargaining agreement exists or is currently being negotiated by Seller or its Wholly Owned Subsidiaries; (ii) no application for certification of a collective bargaining agent is pending; (iii) no demand has been made upon Seller or its Wholly Owned Subsidiaries for recognition by a labor organization; (iv) no union representation question exists; (v) no union organizing activities are, to the Knowledge of Seller, taking place; and (vi) none of the employees of Seller or its Wholly Owned Subsidiaries is represented by any labor union or organization.

(c) Except as set forth in Schedule 3.20(c), Seller and its Wholly Owned Subsidiaries have complied in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; neither Seller, nor its Wholly Owned Subsidiaries, are liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the Knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other entity), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other entity), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.20(d) (or as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.20(d)) states the number of employees terminated by Seller or any of its Wholly Owned Subsidiaries within ninety (90) days prior to the Closing Date, laid off by Seller or any of its Wholly Owned Subsidiaries within the six (6) months prior to the Closing Date, or whose hours of work have been reduced by more than fifty percent (50%) by Seller or any of its Wholly Owned Subsidiaries in the six (6) months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours; (ii) the reason for termination, layoff, or reduction in work hours; and (iii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.20(d), neither Seller, nor its Wholly Owned Subsidiaries, has violated the Worker Adjustment and Retraining Notification Act ("**WARN Act**") or any similar state or local Legal Requirements.

(e) To the Knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller or any of its Wholly Owned Subsidiaries is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the Hospital Businesses; or (ii) to assign to Seller or to any other Person any rights to any invention, improvement, or discovery. To the Knowledge of Seller, no former or

current employee of Seller or any of its Wholly Owned Subsidiaries at the Hospital Businesses is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as heretofore carried on by Seller prior to Closing.

(f) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller, its Wholly Owned Subsidiaries or the Hospital Businesses requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To the Knowledge of Seller, no employee of Seller, its Wholly Owned Subsidiaries or the Hospital Businesses who is a foreign national has ever worked without employment authorization from the Department of Homeland Security or any other Governmental Authority that must authorize such employment and Seller have complied with applicable immigration laws with respect to the employment of foreign nationals. To the Knowledge of Seller, Seller and its Wholly Owned Subsidiaries have timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no proceedings pending or, to Seller's Knowledge, threatened against Seller or any of its Wholly Owned Subsidiaries relating to Seller's or any Wholly Owned Subsidiary's compliance with federal immigration regulations, including compliance with federal immigration laws. Except as set forth on Schedule 3.20(g), neither Seller, nor any of its Wholly Owned Subsidiaries, has received any letter from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and neither Seller, nor any of its Wholly Owned Subsidiaries, has received any letter or other correspondence from the Department of Homeland Security or other Government Authority regarding the employment authorization of any employees of Seller or its Wholly Owned Subsidiaries. If Seller or any of its Wholly Owned Subsidiaries operates in a state or has Contracts with a Governmental Authority that requires or provides a safe harbor if an employer participates in the Department of Homeland Security's e-Verify electronic employment verification system, Seller or any of its Wholly Owned Subsidiaries, as applicable, has been participating in e-Verify for the entire period such participation has been required or available as a safe harbor or as long as Seller or any such Wholly Owned Subsidiary has been operating in such state or contracting with such Governmental Authority.

(g) To the Knowledge of Seller, all employees, former employees and independent contractors of Seller or its Wholly Owned Subsidiaries have been properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state law equivalent.

3.21. Employee Benefit Plans.

(a) Schedule 3.21 contains a list of all benefit plans maintained by Seller and its Wholly Owned Subsidiaries within the last five (5) years with respect to its employees (whether tax-qualified or nonqualified, currently effective or terminated, written or unwritten) including, without limitation, any of the following:

(i) employee pension benefit plan (as defined in Section 3(2) of ERISA), including, without limitation, any pension, profit-sharing, or stock bonus plan (as described in Section 401(a) of the Code, and related provisions thereof), defined benefit plan or defined contribution plan (as defined in ERISA Sections 3(34) and 3(35)), governmental plan, or church plan;

(ii) annuity contracts purchased by Seller or its Wholly Owned Subsidiaries for employees of the Hospital Businesses in accordance with Code Section 403(b) including, without limitation, any group annuity contracts, individual annuity contracts, and custodial account arrangements under Code Section 403(b)(7), regardless of whether contributions are made to such annuity contracts on a pre-tax or after-tax basis;

(iii) employee welfare benefit plan (as defined in ERISA Section 3(1)) including, without limitation, any health (including, without limitation, medical, dental, or vision) plan, life-insurance plan, death benefit plan, short-term disability plan, long-term disability plan, accident plan, accidental death and dismemberment plan, long-term care plan, or employee assistance plan;

(iv) fringe benefit plan, including, without limitation, any specified fringe benefit plan (as defined in Code Section 6039D), cafeteria plan, or tuition assistance plan;

(v) executive compensation or incentive plan, including, without limitation, any bonus plan, incentive-compensation plan, deferred-compensation plan, non-qualified profit-sharing plan, stock-option plan, stock-appreciation-right plan, stock-bonus plan, stock-purchase plan, employee-stock-ownership plan, or savings plan;

(vi) post-termination benefits plan including, without limitation, any severance plan, change-in-control plan, supplemental-unemployment plan, layoff plan, salary-continuation plan, or non-qualified retirement plan; or

(vii) vacation, holiday, sick-leave, paid-time-off, or other employee compensation plan, procedure, program, payroll practice, policy, agreement, commitment, contract, or understanding;

and any such plan or other arrangement that (i) is maintained or contributed to by Seller or any other corporation or trade or business controlled by, controlling, or under common control with Seller (within the meaning of Code Section 414 or ERISA Sections 4001(a)(14) or 4001(b)) ("**ERISA Affiliate**"), or with respect to which Seller or any ERISA Affiliate has or may have any liability; or (ii) provides benefits, or describes a plan, procedure, program, payroll practice, policy,

agreement, commitment, contract, or understanding applicable to any current or former director, officer, employee, or individual service provider of Seller or any ERISA Affiliate, or the dependents of any thereof, regardless of how (or whether) liabilities for the provision of benefits are accrued or assets are acquired or dedicated with respect to the funding thereof. All such plans or arrangements that are set forth on Schedule 3.21 are referred to hereinafter collectively as the "**Employee Benefit Plans**."

(b) Seller has delivered to Buyer accurate and complete copies of (i) the current documents comprising each Employee Benefit Plan (or, with respect to any Employee Benefit Plan that is unwritten, a detailed written description thereof); (ii) all current trust agreements or other funding instruments related to each Employee Benefit Plan, if any; (iii) all formal rulings, letters, and opinions regarding each Employee Benefit Plan from the IRS, the DOL, PBGC, or any other Governmental Authority that pertains to each Employee Benefit Plan that have been issued within the last three (3) years and any open requests therefor; (iv) the annual reports filed with any Governmental Authority with respect to each Employee Benefit Plan during the current year and each of the three (3) preceding years, if any; (v) all current contracts with third-party administrators, consultants, and other independent contractors that relate to each Employee Benefit Plan; (vi) all current summary plan descriptions, summaries of material modifications and memoranda, and other written communications regarding each Employee Benefit Plan currently in effect, if applicable; and (vii) documents evidencing compliance with the privacy requirements under HIPAA relating to each Employee Benefit Plan, as to which such requirements apply.

(c) Except as provided on Schedule 3.21:

(i) Each Employee Benefit Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with all applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Employee Benefit Plan and applicable Legal Requirements;

(ii) Neither Seller nor any ERISA Affiliate has any material liability under any Employee Benefit Plan for which Buyer has or will have any liability (other than liability for any regular annual contributions required under such Employee Benefit Plans), contingent or otherwise, under Titles I or IV of ERISA or the Code, including, without limitation, any liability with respect to any "multiemployer plan" (as defined in ERISA Sections 3(37)(A) or Section 4001(a)(3) or Code Section 414(f) ("**Multiemployer Plan**"), multiple employer plan (as described in Code Section 413(c)), or "single-employer plan" (as defined in ERISA Section 4001(a)(15)), whether or not terminated; self-insured or self-funded "multiple employer welfare arrangement" as such term is defined in ERISA Section 3(40); prohibited transaction (pursuant to Code Section 4975 or ERISA Section 406) with any Employee Benefit Plan that is not subject to an exemption under Code Section 4975 or ERISA Section 408 or the regulations

thereto; excise tax or penalty imposed under ERISA or the Code with respect to any Employee Benefit Plan; or breach of any responsibilities or obligations imposed upon fiduciaries by Title I of ERISA with respect to any Employee Benefit Plan.

(iii) Each Employee Benefit Plan that is an "employee pension benefit plan" as defined in ERISA Section 3(2) other than a Multiemployer Plan and each related trust agreement, annuity contract, or other funding instrument is and has been since its inception intended to be qualified and tax-exempt under the provisions of Code Sections 401(a) and 501(a), or, if applicable, Code Section 403(b), and, for each such Employee Benefit Plan that is not stated on a master and prototype and/or volume submitter plan on which reliance is and can be based on a favorable opinion or advisory letter without the adopting employer having requested an individual determination letter, has been determined by the IRS pursuant to an individual favorable determination letter to be so qualified and tax-exempt or an application for such determination has been made and is currently pending; has not participated in any voluntary compliance or self-correction programs established by the IRS (or the DOL with respect to any fiduciary issues), or entered into a closing agreement with the IRS with respect to the form or operation of any Employee Benefit Plan within the six (6) years preceding the Closing Date; does not have and during the six (6) years preceding the Closing Date has not had any "unfunded accrued liability," as such term is defined under ERISA Section 3(30); has not experienced any "reportable events," as such term is defined under ERISA Section 4043, for which a waiver has not been granted; has not had any "accumulated funding deficiencies," as such term is defined under ERISA Section 302(a)(2) (prior to amendment by P.L. 109-280) or Code Sections 412(a) or 4971 (whether or not waived), nor for years after amendment by P.L. 109-280 any "funding shortfalls" as defined in Code Section 430(c); does not have any liabilities required to be disclosed on any annual report (Form 5500 series) that have not been disclosed; and has not been terminated.

(iv) With respect to each Employee Benefit Plan that is not an "employee pension benefit plan," as defined in ERISA Section 3(2), such plan may be terminated at the time of Closing according to its terms without any prior notice; no commitments have been made to provide lifetime or retiree benefits under any such plan; and no persons have any vested rights under any such plan.

(v) Each Employee Benefit Plan that is a "group health plan," as defined in ERISA Section 607(1) or Code Section 5000(b)(1), and that is maintained by Seller or any ERISA Affiliate has been operated at all times during the six (6) years preceding the Closing Date in material compliance with ERISA, to the extent applicable, the Code, the Social Security Act, and HIPAA.

(vi) All required contributions to all Employee Benefit Plans and all premiums, fees, or other payments required to be made by Seller or any ERISA Affiliate in connection with any Employee Benefit Plan have either been timely made or are reflected in the financial statements on an accrual basis. All returns,

reports, and disclosure statements required to be made under the Code, ERISA, to the extent applicable, or other applicable law with respect to the Employee Benefit Plans other than a Multiemployer Plan have been timely filed or delivered.

(vii) No Employee Benefit Plan is currently or has been within the last three (3) years under audit, inquiry, or investigation by the IRS, DOL, or PBGC, and there are no outstanding issues with reference to such Employee Benefit Plans pending before any governmental agency. Other than routine claims for benefits, there are no actions, mediations, audits, arbitrations, suits, claims, or investigations pending, or to the Knowledge of Seller or any ERISA Affiliate, threatened against or with respect to any of the Employee Benefit Plans sponsored by Seller or any ERISA Affiliate or their assets, and there are no threatened or pending claims by or on behalf of such Employee Benefit Plans or by any employee of Seller or any ERISA Affiliate alleging a breach or breaches of fiduciary duties or violations of other applicable state or federal law that could result in liability on the part of either Seller, any ERISA Affiliate or such Employee Benefit Plans under any law, nor is there any basis for such a claim.

(viii) Seller and its Wholly Owned Subsidiaries do not have any contracts, agreements, plans, or arrangements under which the contemplated transaction will result in any (i) payments (whether of separation pay or otherwise) becoming due from Seller or any ERISA Affiliate to any current or former employee, director, or consultant, or (ii) vesting, acceleration of payment, or increase in the amount of any benefit payable to or in respect of any such current or former employee, director, or consultant of Seller or any ERISA Affiliate that will, in turn, result in any liability to Buyer.

3.22. Proceedings and Legal Claims. Seller has delivered to Buyer an accurate list and summary description (Schedule 3.22) of all pending or, to the Knowledge of Seller, threatened Proceedings and legal claims with respect to the Seller, each Wholly Owned Subsidiary, the Hospital Businesses, and the Assets. Neither Seller nor any Wholly Owned Subsidiary is in default under any order of any Governmental Authority wherever located. Except as set forth in a writing delivered by Seller to Buyer that specifically makes reference to this Section 3.22 or as set forth on Schedule 3.22, there are no claims, Proceedings, or investigations pending or, to the Knowledge of Seller, threatened against the Seller, any Wholly Owned Subsidiary, the Hospital Businesses or the Assets, at law or in equity, or before or by any Governmental Authority wherever located. With respect to insured claims, no carrier has issued a "reservation of rights" letter or otherwise denied its obligation to insure and defend Seller, or any of its Wholly Owned Subsidiaries, against covered losses arising therefrom.

3.23. Taxes.

(a) Seller and its Wholly Owned Subsidiaries have filed on a timely basis, or validly extended the time for filing, all federal, state, and local Tax Returns. All Tax Returns are true and correct in all material respects and accurately reflect in all material respects the Tax liabilities of Seller and its Wholly Owned Subsidiaries. All

amounts shown due on the Tax Returns have been or will be paid on a timely basis (including any interest or penalties and amounts due state unemployment authorities) to the appropriate tax authorities.

(b) Seller and its Wholly Owned Subsidiaries, as applicable, have withheld all proper amounts from the compensation of its employees in compliance with all withholding and similar provisions of the Code, including employee withholding and social security taxes, and any and all other applicable laws. All such amounts have been duly and validly remitted to the proper taxing authority. Further, Seller and its Wholly Owned Subsidiaries have withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by them to independent contractors, creditors and other Persons for which withholding or payment is required by applicable Legal Requirements.

(c) No deficiencies for any Taxes relating to the Seller or its Wholly Owned Subsidiaries have been asserted or, to the Knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the Knowledge of Seller, threatened. There are no outstanding agreements by Seller or its Wholly Owned Subsidiaries for the extension of time for the assessment of any Taxes. Seller and its Wholly Owned Subsidiaries have not taken any action in respect of any Taxes that may have a material adverse effect upon the Hospital Businesses or the Assets as of or subsequent to Closing.

(d) To Seller's knowledge, no Government Authority intends to assess any additional Taxes for any period for which Tax Returns have been filed. No claim has ever been made by a Government Authority in a jurisdiction where Seller or any Wholly Owned Subsidiary does not file Tax Returns that such entity is or may be subject to Tax in that jurisdiction. Neither Seller nor any of its Wholly Owned Subsidiaries has received written notice of Tax liens on any of the Assets.

(e) Seller is not a party to any Tax allocation or sharing contract. Seller is not, and has not been, a member of any affiliated group within the meaning of Section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law filing a consolidated federal income Tax Return.

(f) Each of Seller and its Wholly Owned Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the IRS and the State of Connecticut regarding such Tax status and nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption.

(g) Neither Seller, nor its Wholly Owned Subsidiaries, has any liability for the Taxes of any other person or entity (other than a subsidiary under IRS regulation 1.1502-6), as a transferee or successor, by contract or otherwise.

3.24. Medical Staff; Physician Relations. Seller has provided to Buyer true, correct, and complete copies of the bylaws and rules and regulations of the medical staff of the Hospital,

as well as a list of all current members of the medical staff. Except as set forth in Schedule 3.24, there are no adverse actions with respect to any medical staff members of the Hospital or any applicant thereto for which a medical staff member or applicant has requested a judicial review hearing that has not been scheduled or has been scheduled but has not been completed, and there are no pending or, to the Knowledge of Seller, threatened disputes with applicants, staff members, or health professional affiliates, and Seller knows of no basis therefor, and all appeal periods in respect of any medical staff member or applicant against whom an adverse action has been taken have expired. No member of the medical staff of the Hospital has been excluded from participation in any Government Payment Program.

3.25. Restricted Assets. Except as set forth on Schedule 3.25 hereto, neither Seller, its Wholly Owned Subsidiaries nor any of their predecessors has received any loans, grants, or loan guarantees pursuant to the Hill-Burton Act program, the Health Professions Educational Assistance Act, the Nurse Training Act, the National Health Planning and Resources Development Act, and the Community Mental Health Centers Act, as amended, or similar laws or acts relating to health care facilities. The transactions contemplated hereby will not result in any obligation on Buyer or any of its Affiliates to repay any of such loans, grants, or loan guarantees, nor subject Buyer, its Affiliates, or the Assets to any lien, restriction, or obligation, including any requirement to provide uncompensated care.

3.26. Brokers and Finders. Except for Cain Brothers, which is representing Seller, neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.27. Payments. None of the Hospital Businesses has, to Seller's Knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Neither Seller nor any of its Wholly Owned Subsidiaries has, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor any of its Wholly Owned Subsidiaries, nor to Seller's Knowledge, any officer, director or trustee of Seller or any Wholly Owned Subsidiary has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom Seller or any Wholly Owned Subsidiary conducts or has conducted any of the Hospital Businesses.

3.28. Joint Ventures.

(a) Schedule 3.28 sets forth for each Joint Venture, [and as of the Closing Date, also for each Converted Venture]: (i) its name and jurisdiction of incorporation or organization; (ii) the number of authorized shares of each class of its capital stock or other equity or non-equity interests; (iii) the number of issued and outstanding shares of each class of its capital stock or other equity or non-equity interests, the names of the holders thereof, and the number of shares or other equity or non-equity interests held by each such holder; (iv) the number of shares of its capital stock or

other equity interests held in treasury; and (v) its directors and officers, general partners, or managers, as the case may be. Seller does not hold any equity interest in any entity other than its Wholly Owned Subsidiaries and the Joint Ventures[, and as of the Closing Date, the Converted Ventures].

(b) Subject to Section 5.19, each Joint Venture: (i) if it is a for profit or nonprofit corporation, is duly incorporated and validly existing under the laws of the state of its incorporation and is duly qualified and in good standing as a foreign corporation in the jurisdiction of its principal place of business if not incorporated therein; (ii) if it is a limited liability company, is duly organized, validly existing, and, if applicable, in good standing under the laws of the state of its organization and is duly qualified and, if applicable, in good standing as a foreign limited liability company in the jurisdiction of its principal place of business if not organized therein; and (iii) if it is a partnership, trust, or other entity, is duly formed, validly existing, and, if applicable, in good standing in the jurisdiction of its principal place of business if not formed therein. To the Knowledge of Seller, each Joint Venture, [and as of the Closing Date, each Converted Venture,] has full corporate, limited liability company, partnership, trust, or other applicable power and authority and all licenses and permits (including authorizations to do business in any applicable state) necessary to carry on the businesses in which it is engaged and in which it presently proposes to engage, and to own and use the properties owned and used by it. To the Knowledge of Seller, each Joint Venture, [and as of the Closing Date, each Converted Venture,] has not materially violated any Legal Requirement or material Contract or agreement.

(c) Seller has delivered to Buyer accurate and complete copies, as applicable, of the articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholder or membership agreement, as amended to date and in its possession, of each Joint Venture[, and as of the Closing date, of each Converted Venture]. Except as set forth on Schedule 3.28 hereto, all of the issued and outstanding shares of capital stock or other equity or non-equity interests of each Joint Venture, and as of the Closing Date, of each Converted Venture, that have been issued to Seller (or any Wholly Owned Subsidiary thereof) have been duly authorized and are validly issued, fully paid, and nonassessable. To the Knowledge of Seller, none of the Joint Ventures, [and as of the Closing Date,] none of the Converted Ventures, is in default under or in violation of any provision of its articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholders or membership agreement.

(d) Except as set forth in Schedule 3.28, to the Knowledge of Seller, (i) there is no outstanding subscription, option, convertible or exchangeable security, preemptive right, warrant, call, or agreement (other than this Agreement) relating to the stock or other equity or non-equity interests of the Joint Ventures, [and as of the Closing Date, the Converted Ventures], or other obligation or commitment of any Joint Venture, [and as of the Closing Date, of any Converted Ventures], to issue any shares of capital stock or other equity interests; and (ii) there are no voting trusts or other agreements, arrangements, or understandings applicable to the exercise of voting or any other rights with respect to any shares of Joint Venture stock or other equity or

non-equity interests[, and as of the Closing Date, to any shares of Converted Venture stock or other equity or non-equity interests]. Seller (or any Wholly Owned Subsidiary thereof) has good, marketable, and indefeasible title to all shares of the stock or other equity or non-equity interests of the Joint Ventures, [and as of the Closing Date, of the Converted Ventures,] set forth in Schedule 3.28 and, except as set forth on Schedule 3.28, has the absolute right to sell, assign, transfer, and deliver the same to the Buyer, free and clear of all claims, security interests, liens, pledges, charges, escrows, options, proxies, rights of first refusal, preemptive rights, mortgages, hypothecations, prior assignments, title retention agreements, indentures, security agreements, or any other limitation, encumbrance, or restriction of any kind.

(e) Except as set forth in Schedule 3.28, to the Knowledge of Seller, the Joint Ventures, [and as of the Closing Date, the Converted Ventures,] do not control, directly or indirectly, or have any direct or indirect equity participation in any corporation, limited liability company, partnership, trust, or other business association.

3.29. Quality and Condition of Assets. The Assets and the Excluded Assets constitute all assets that are held or used by Seller or its Wholly Owned Subsidiaries for the conduct of the Hospital Businesses in the manner conducted as of the date of this Agreement. Except as set forth in Schedule 3.29, to the Knowledge of Seller, all buildings, structures, facilities, and Material Tangible Assets included in the Assets are free from material defects and are usable in the regular and ordinary course of business, and conform in all material respects to all applicable Legal Requirements relating to their use and operation by Seller or its Wholly Owned Subsidiaries.

3.30. Experimental Procedures. Seller (or any Wholly Owned Subsidiary thereof) has not performed or permitted the performance of any experimental or research procedures or studies involving patients of the Hospital Businesses not authorized and conducted in accordance with the procedures of the Institutional Review Board of the Hospital.

3.31. Full Disclosures. This Agreement, the Schedules hereto, and all Closing Documents furnished and to be furnished to Buyer and their representatives by Seller pursuant hereto, when taken in their entirety, do not and will not include any untrue statement of a material fact. Copies of all documents referred to in any Schedule hereto in the possession of Seller have been delivered or made available to Buyer and its representatives and constitute true, correct, and complete copies thereof and include all amendments, exhibits, schedules, appendices, supplements, or modifications thereto or waivers thereunder.

4. REPRESENTATIONS OF BUYER

Buyer makes the following representations to Seller on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization.

(a) Buyer is a corporation duly organized and validly existing and in good standing under the laws of Connecticut. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease

and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. Buyer has made available to Seller a true and complete copy of its organizational documents.

(b) PMH is a corporation duly organized and validly existing and in good standing under the laws of Delaware. PMH has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing.

4.02. Power and Authority; Due Authorization.

(a) Buyer has full power and authority to (i) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (ii) perform its obligations under this Agreement and such Closing Documents and (iii) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary corporate action.

(b) PMH has full power and authority to (i) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (ii) perform its obligations under this Agreement and such Closing Documents and (iii) consummate the transactions contemplated by this Agreement. The execution and delivery by PMH of this Agreement and the Closing Documents to which it is or becomes a party, the performance by PMH of its obligations under this Agreement and such Closing Documents, and the consummation by PMH of the transactions contemplated by this Agreement have been duly authorized on behalf of PMH by all necessary corporate action.

4.03. Consents; Absence of Conflicts, Etc.

(a) The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(i) are within its corporate powers, are not in contravention of its certificate of incorporation, shareholders agreement, and bylaws and have been approved by all required corporate action;

(ii) do not violate any Legal Requirement to which it is subject;

(iii) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound;

(iv) will not violate any statute, law, rule, or regulation of any governmental authority to which it may be subject; and

(v) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which it may be subject.

(b) The execution, delivery and performance by PMH of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(i) are within its corporate powers, are not in contravention of its certificate of incorporation, shareholders agreement, and bylaws and have been approved by all required corporate action;

(ii) do not violate any Legal Requirement to which it is subject;

(iii) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound;

(iv) will not violate any statute, law, rule, or regulation of any governmental authority to which it may be subject; and

(v) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which it may be subject.

4.04. Due Execution; Binding Agreement. This Agreement has been duly and validly executed and delivered by Buyer. Each Closing Document to which Buyer will be a party will be duly and validly executed and delivered by Buyer at the Closing. This Agreement constitutes, and each of the Closing Documents to which Buyer will be a party will constitute (upon execution and delivery thereof by Buyer at the Closing), the valid and legally binding obligations of Buyer, enforceable against it in accordance with the terms hereof and thereof.

4.05. Proceedings. There are no claims, Proceedings, or investigations pending or, to Buyer's knowledge, threatened that: (a) adversely affect or seek to prohibit, restrain, or enjoin the execution and delivery of this Agreement, (b) adversely affect or question the validity or enforceability of this Agreement, (c) question the power or authority of Buyer to carry out the transactions contemplated by, or to perform its obligations under, this Agreement, or (d) would result in any change that would adversely affect in any material respect the ability of Buyer to perform any of its obligations hereunder.

4.06. Availability of Funds. Buyer will have and will apply at the time of Closing sufficient cash or other immediately available funds necessary to enable Buyer to consummate the transactions contemplated hereby in accordance with the terms hereof.

5. PRE-CLOSING COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by Buyer, Seller will, and will require its Affiliates and Wholly Owned Subsidiaries to:

(a) carry on its business pertaining to the Hospital Businesses in substantially the same manner as presently conducted and not make any material change in personnel, operations, finance, accounting policies, or real or personal property pertaining to the Hospital Businesses;

(b) maintain the Hospital Businesses and all parts thereof in good operating condition, ordinary wear and tear excepted;

(c) perform all of its material obligations under agreements relating to or affecting the Hospital Businesses or the Assets;

(d) comply in all material respects with all applicable laws and other Legal Requirements;

(e) keep in full force and effect present insurance policies or other comparable insurance pertaining to the Hospital Businesses; and

(f) use its commercially reasonable efforts to maintain and preserve its business organizations intact, retain its present employees of the Hospital Business, and maintain its relationships with physicians, suppliers, customers, and others having business relations with the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to by Buyer in writing, Seller will not, and will not permit any Affiliate or Wholly Owned Subsidiary to:

(a) amend or terminate any of the Assumed Contracts, enter into any Contract or commitment, or incur or agree to incur any liability, except as provided herein or in the ordinary course of business and in no event greater than Seventy-Five Thousand Dollars ($75,000) per item;

(b) enter into any Contract or commitment with physicians or other referral sources;

(c) increase compensation payable or to become payable or make any bonus payment to or otherwise enter into one or more bonus agreements with any employee of the Hospital Businesses, except increases in compensation or bonus payments or agreements that are otherwise made in the ordinary course of business consistent with past practices and in accordance with existing personnel policies;

(d) create, assume, or permit to exist any new debt, mortgage, pledge, or other lien or encumbrance upon any of the Assets in an amount in excess of Seventy-Five Thousand Dollars ($75,000) whether now owned or after acquired;

(e) acquire (whether by purchase or lease) or sell, assign, lease, or otherwise transfer or dispose of any property (including Real Property), plant, or equipment having a net book value in excess of Seventy-Five Thousand Dollars ($75,000), except in the ordinary course of business;

(f) purchase capital assets other than in accordance with the approved capital budget of Seller previously provided to Buyer;

(g) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided;

(h) hire or terminate the employment of any employee of the Hospital Businesses at the level of manager or higher (including, without limitation, any officer of the Hospital Businesses);

(i) sell or factor any Accounts Receivable;

(j) cancel, forgive, release, discharge or waive any Person's obligation to pay or to perform obligations in respect of any Assets, or agree to do any of the foregoing, except in the ordinary course of the business of the Hospital Businesses consistent with past practices;

(k) change any accounting method, policy or practice or reduce any reserves in the Financial Statements, except (i) reductions in reserves pertaining to Government Payment Programs or third party payors made in the ordinary course of business consistent with past practices and (ii) changes required by changes in GAAP or applicable Legal Requirements;

(l) terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for amendments required to comply with this Agreement or applicable Legal Requirements;

(m) amend or agree to amend the governing documents of any Joint Venture, except (x) immaterial amendments or amendments required to comply with applicable Legal Requirements or to assign and transfer to Buyer the Seller's ownership interest in, or for Buyer to become a partner or member of, the Joint Venture, or (y) as contemplated by Section 5.19 hereof; or

(n) take any action outside the ordinary course of business of the Hospital Businesses or their related ancillary services.

5.03. Employee Matters.

(a) As of the Closing Date, Seller shall terminate all of its employees at the Hospital Businesses, and Buyer shall offer employment to all active employees in good standing as of the Closing Date who satisfy customary pre-employment screening procedures, in positions similar to those then being provided by Seller. Nothing herein shall be deemed to affect or limit in any way normal management prerogatives of Buyer with respect to employees or to create or grant to any such employees third party beneficiary rights or claims of any kind or nature. In respect of the employees employed by Buyer as of the Closing Date, and except as limited by the terms of applicable collective bargaining agreements, Buyer shall provide such employees with regionally competitive wages and employee benefits comparable to the wages and benefits generally offered to employees of other hospitals owned and operated by Buyers as of the Closing Date and shall honor prior length of service for purposes of determining eligibility and vesting in its benefit plans; *provided, however*, that no such prior service credit need be given in respect of any new plan commenced or participated in by Buyer and generally applicable to other hospitals owned and operated by Buyer in which no prior service credit is given to or recognized for other plan beneficiaries. In extending such benefits, Buyer shall give such employees credit for the satisfaction of pre-existing condition limitations in its welfare benefit plans to the same extent that such employees have satisfied such limitations under the current welfare benefit plans of Seller. Notwithstanding anything to the contrary contained in this Section 5.03, Buyer shall not have any obligation to offer employment to, or continue to employ, any employee (x) at the Hospital Businesses who has been excluded from participation in federal health care programs, or (y) whose name is not set forth on the Employee Lists.

(b) Not later than fifteen (15) days prior to the Closing, Seller shall deliver to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Wholly Owned Subsidiaries (indicating in the list whether each employee is classified as exempt or nonexempt by Seller or such Wholly Owned Subsidiary), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Wholly Owned Subsidiaries (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor) (collectively, the "**Employee Lists**").

5.04. Access to and Provision of Additional Information.

(a) Seller shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Buyer full and complete access to and the right to inspect the plants, properties, books, and records of the Hospital Businesses, and will furnish Buyer with such additional

financial and operating data and other information as to the business and properties of Seller pertaining to the Hospital Businesses as Buyer may from time to time reasonably request without regard to where such information may be located. Buyer's right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Hospital Businesses and the delivery of patient care. Buyer agrees that no inspections shall take place and no employees or other personnel of the Hospital Businesses shall be contacted by Buyer without Buyer's first providing reasonable notice to Seller and coordinating such inspection or contact with Seller.

(b) Within two (2) business days after they are created (but in any event no later than fifteen (15) days following the end of each calendar month prior to Closing), Seller shall deliver or cause to be delivered to Buyer true and complete copies of the management prepared unaudited balance sheets and the related unaudited statements of income of, or relating to, Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses for each month then ended, which presentation shall be true, correct, and complete in all material respects, shall have been prepared from and in accordance with the books and records of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses, and shall fairly present the financial position and results of operations of Seller and its Wholly Owned Subsidiaries in respect of the Hospital Businesses as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such financial statements need not include required footnote disclosures. To the extent permitted by law, Seller shall notify Buyer in writing and shall keep Buyer informed of any unexpected emergency or other materially adverse unanticipated change in the business of any of the Hospital Businesses and of any governmental complaints, investigations, or adjudicatory proceedings (or governmental communications indicating that the same may be contemplated) or of any other such matter.

(c) Until the Closing Date, to the extent permitted by law, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, grievances, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any individually identifiable health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with HIPAA and with any other Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this Section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Governmental Approvals.

(a) Seller's Obligations.

(i) Seller shall (a) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Seller to perform its obligations under this Agreement (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein); and (b) assist and cooperate with Buyer and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Buyer deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein).

(ii) Seller shall, if and to the extent required by Legal Requirements, file all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Seller agrees to furnish to Buyer such information concerning Seller as Buyer needs to perform its obligations under Section 5.05(b)(ii) of this Agreement.

(b) Buyer's Obligations.

(i) Buyer shall (a) use its commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow Buyer to perform its obligations under this Agreement (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein), and (b) assist and cooperate

with Seller and its representatives and counsel in obtaining all governmental consents, approvals, and licenses that Seller deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Authority as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein). Buyer shall pay all of the costs of any fees due in respect of filings made to the Attorney General and Commissioner of Public Health of the State of Connecticut, including, without limitation, fees required to be paid by Buyer pursuant to CT Gen Stat § 19a-486c(c) and CT Gen Stat § 19a-486d(a) shall remain the obligation of Buyer.

(ii) Buyer shall, if and to the extent required by Legal Requirements, file or cause to be filed all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act, and all regulations promulgated thereunder, concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Buyer agrees to furnish to Seller such information concerning Buyer as Seller needs to perform its obligations under Section 5.05(a)(ii) of this Agreement. Buyer shall pay the costs of any fees due in respect of filings required by the HSR Act.

5.06. Connecticut Transfer Act. Certain components of the Real Property (including the Hospital) may constitute, in whole or in part, "Establishments" as the term is defined in the Transfer Act (collectively, the "**Establishment Real Properties**"). Accordingly, Seller and Buyer shall prepare an appropriate Transfer Act Form and accompanying Environmental Condition Assessment ("**ECAF**") for each Establishment Real Property to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Seller shall execute as transferor and Buyer shall execute as transferee and Certifying Party (as all such terms are defined in the Transfer Act). Within ten (10) days after the Closing Date, Buyer shall (i) file the fully executed Transfer Act Form and ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEEP**"); (ii) pay the initial filing fee and any and all subsequent Transfer Act fees (which shall be reimbursed by Seller); and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). In order to evaluate the potential scope and cost of Transfer Act obligations that may be required, prior to the Closing, Buyer shall have the right to perform limited Phase II assessments with respect to the Real Property. Buyer or its designee shall conduct and complete, at Buyer's sole expense, any actions required (as determined by Buyer in its reasonable discretion) as a result of the filing of the Transfer Act Form and the ECAF, to comply with the Transfer Act, and, if appropriate, to obtain written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" that the Hospital Businesses have been remediated in full compliance with the Connecticut Remediation Standard Regulations (collectively "**Transfer**

Act Activities"). Buyer shall complete all Transfer Act Activities as soon as practicable, but in any event within any deadline defined by or pursuant to the Transfer Act (as the same may be extended). Notwithstanding the foregoing **[need to have an approval process to review costs]**[10], Seller shall pay Buyer for all costs and expenses that Buyer incurs in connection with Transfer Act Activities. Seller and Buyer agree to execute and deliver all documents reasonably requested by the other to comply with the Transfer Act. All undefined terms in this Section 5.06 shall have the meanings set forth in the Transfer Act. Notwithstanding anything to the contrary in this Agreement, the parties agree that any and all fees, expenses and other costs to be paid by Seller under this Section 5.06 shall be paid first from funds held as part of the indemnity reserve established pursuant to Section 10.09.

5.07. No-Shop Clause. Seller agrees that, from and after the date of the execution and delivery of this Agreement by Seller until the termination of this Agreement, neither Seller, nor any Affiliate of Seller will, without the prior written consent of Buyer: (i) offer for sale the Assets (or substantially all of the Assets) or any ownership interest in any entity owning any of the Assets, (ii) solicit offers to buy all or substantially all of the Assets or any ownership interest in any entity owning any of the Assets, (iii) hold discussions with any party (other than Buyer) looking toward such an offer or solicitation or looking toward a merger, consolidation, joint venture, or similar transaction involving any entity owning any of the Assets, or (iv) enter into any agreement with any party (other than Buyer) with respect to the sale or other disposition of the Assets (or substantially all of the Assets) or any ownership interests in any entity owning any of the Assets or with respect to any merger, consolidation, joint venture, or similar transaction involving any entity owning any of the Assets. Seller will promptly communicate to Buyer the substance of any inquiry or proposal concerning any such transaction.

5.08. Casualty. If, on or before the Closing Date, any of the Real Property used by the Hospital Businesses is destroyed or damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Real Property, in the aggregate, is rendered unsuitable for their primary intended use for at least six (6) months, Buyer may elect, by giving written notice to Seller within ten (10) business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this Agreement in accordance with Section 9.04(a)(v), (ii) consummate the transaction in spite of such destruction or damage, but reduce the Purchase Price by the fair market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds (or the right to receive the insurance proceeds) payable on account of such destruction or damage, plus any deductibles or copayments required under the applicable insurance policy in respect of such claim. In the absence of an agreement among the parties regarding the amount of any Purchase Price reduction for purposes of clause (ii) above (if applicable), an MAI appraiser mutually selected by the parties and paid equally by Seller, on the one hand, and Buyer, on the other hand, will determine any reduction in Purchase Price pursuant to such clause (ii).

[10] Subject to review

5.09. Consents to Assignment.

(a) Seller shall (or shall cause its Wholly Owned Subsidiaries to) promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing, provided that Seller and its Wholly Owned Subsidiaries shall not be required to make any payments or economic concessions to landlords or other counterparties to obtain such consents.

(b) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a contract that supersedes or replaces an existing Contract between Seller (or its Wholly Owned Subsidiary) and a third party. Such new contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller (or its Wholly Owned Subsidiary) that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller (or its Wholly Owned Subsidiary) that are Excluded Liabilities. If Buyer enters into a replacement contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 10), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement contract did not exist or such assumption of Excluded Liabilities was not required.

5.10. Insurance Ratings. Seller will take all action reasonably requested by Buyer to enable Buyer to succeed to the workers' compensation and unemployment insurance ratings, and other ratings for insurance or other purposes established by Seller or its Affiliates for the Hospital Businesses. Buyer shall not be obligated to succeed to any such ratings, except as Buyer may elect to do so.

5.11. Efforts to Close.

(a) Seller shall use its commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Seller shall notify Buyer as soon as practicable of any event or matter that comes to its attention that may reasonably be expected to prevent or materially delay the conditions to the obligations of Seller being met.

(b) Buyer shall use its commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Buyer shall notify Seller as soon as practicable of any event or

matter that comes to the attention of Buyer that may reasonably be expected to prevent or materially delay the conditions to Buyer's obligations being met.

5.12. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets, other than the Permitted Encumbrances, to be released and discharged at or before Closing.

5.13. [Intentionally Omitted.]

5.14. Medical Staff Disclosure. Seller shall deliver to Buyer a confidential written disclosure containing a brief description of all adverse actions taken against medical staff members or applicants in the past three (3) years that, to the Knowledge of Seller, could result in claims or actions against Seller, its Wholly Owned Subsidiaries or the Hospital Businesses and that are not disclosed in the minutes of the meetings of the Medical Executive Committee of the medical staff of the Hospital Businesses, **[which have been provided to Buyer.]**[11]

5.15. Satisfaction of Bond Obligations. At its sole cost and expense, Seller shall do all things necessary, desirable, and appropriate to cause the complete and valid payment or, if necessary, defeasance of its obligations under that certain Loan Agreement and Security Agreement dated as of December 1, 2010 by and between Seller, the Hospital, RBS Citizens, National Association, and the State of Connecticut Health and Educational Facilities Authority (the "**Loan Agreement**"), which secures the State of Connecticut Health and Educational Facilities Authority Revenue Bonds, Waterbury Hospital Issue, Series D, such that all liens and mortgages secured by the Loan Agreement shall be released at the time of the Closing.

5.16. New and Existing Collective Bargaining Agreement. **[Pending discussion with Labor counsel]**

(a) Seller is currently party to three collective bargaining agreements:

(i) The "Nurses CBA" is between the Seller and Connecticut Health Care Associates and covers registered nurses and licensed practical nurses with effective dates from October 1, 2013 through September 30, 2017. Neither the Buyer nor the Seller expect that the Nurses CBA shall be renegotiated prior to the Closing. The Seller shall not enter into any modification of the Nurses CBA prior to the Closing without the express written consent of the Buyer. The Buyer shall accept the terms of the Nurses CBA, as adjusted with regard to pension benefits and hire bargaining unit employees as set forth in the Letter of Agreement on Successorship contained in the Nurses CBA. The Buyer shall provide the Union a written notice of such acceptance at least thirty (30) days prior to the Closing in accordance with said Letter of Agreement on Successorship.

(ii) The "Technical Unit CBA" is between the Seller and Connecticut Health Care Associates and covers technical employees with effective dates from December 9, 2015 through September 30, 2018. Neither the Buyer nor the Seller expect that the Technical Unit CBA shall be renegotiated prior to the Closing.

[11] Subject to due diligence

The Seller shall not enter into any modification of the Technical Unit CBA prior to the Closing without the express written consent of the Buyer. The Buyer shall accept the terms of the Technical Unit CBA and hire bargaining unit employees as set forth in the Letter of Agreement on Successorship contained in the Technical Unit CBA. The Buyer shall provide the Union a written notice of such acceptance at least thirty (30) days prior to the Closing in accordance with said Letter of Agreement on Successorship.

(iii) The "Service & Maintenance CBA" is between the Seller and New England Health Care Employees Union, District 1199 with effective dates from March 6, 2013 through February 29, 2016. Negotiations for a successor collective bargaining agreement to the Service & Maintenance CBA may commence prior to the Closing. The Seller shall keep Buyer apprised of, and consult with Buyer regarding, the status of negotiations for a successor collective bargaining agreement to the Service & Maintenance CBA. Seller shall not, without the Buyer's written consent, enter into any new or successor collective bargaining agreement to the Service & Maintenance CBA or extension thereof that contains additional costs and/or terms that differ from the terms of the current Service & Maintenance CBA in a manner that the Buyer reasonably believes will impact Buyer's ability to operate the Hospital after the Closing. Buyer shall not interfere with Seller's bargaining obligations under the National Labor Relations Act. If the purchase becomes effective during the life of the existing Service & Maintenance CBA (including any extensions required thereof by its terms), the Buyer shall accept the terms of that agreement by written notice, to be provided at least thirty (30) days prior to the Closing.

(b) If, prior to the Closing, any bargaining obligations arise to the Seller to a bargaining unit not covered by any of the three existing collective bargaining agreements, Seller shall immediately notify Buyer. The Seller shall keep Buyer apprised of, and consult with Buyer regarding, the status of negotiations for a collective bargaining agreement for any such additional bargaining unit. Seller shall not, without the Buyer's written consent, enter into any collective bargaining agreement covering any such unit that contains terms that the Buyer reasonably believes will impact Buyer's ability to operate the Hospital after the Closing. Buyer shall not interfere with Seller's bargaining obligations under the National Labor Relations Act.

5.17. Title Commitment. Buyer shall obtain a current title commitment (the "**Title Commitment**") issued by [Land Services USA] (the "**Title Company**"), together with legible copies of all exceptions to title referenced therein. The Title Commitment shall set forth the state of title to the Owned Real Property, together with all exceptions or conditions to such title, including, without limitation, all easements, restrictions, rights-of-way, covenants, reservations, and all other encumbrances affecting the Owned Real Property that would appear in an owner's title policy, if issued. The Title Commitment shall contain the express commitment of the Title Company to issue an Owner's Title Policy (the "**Title Policy**") to Buyer in an amount equal to the amount being allocated by the parties to the Owned Real Property insuring good and marketable title to the Owned Real Property subject only to the Permitted Encumbrances with the standard printed exceptions endorsed or deleted as agreed by Buyer.

5.18. Surveys. Seller shall deliver copies of all existing surveys of the Real Property, in its possession, to Buyer. Buyer may obtain, at its sole cost and expense, current as-built surveys of the Real Property (the "**Surveys**"). The Surveys shall meet the requirements of an ALTA/ASCM survey and otherwise be in form and detail satisfactory to Buyer. Unless otherwise agreed by Buyer, the Surveys shall (i) be currently dated; (ii) show the location on the Real Property of all improvements, fences, evidences of abandoned fences, lakes, ponds, creeks, streams, rivers, easements, roads, and rights-of-way; (iii) identify all easements and rights-of-way by reference to the recording information applicable to the documents creating such easements or rights-of-way; (iv) show any encroachments onto the Real Property from any adjacent property, any encroachments from the Real Property onto adjacent property, and any encroachments into any easement or restricted area within the Real Property; (v) locate all existing improvements (such as buildings, power lines, fences, and the like); (vi) locate all dedicated public streets or other roadways providing access to the Real Property, including all curb cuts and all alleys; (vii) locate all set-back lines and similar restrictions covering the Real Property or any part thereof and any violations of such restrictions; and (viii) show thereon a legal description of the boundaries of the Real Property by metes and bounds or other appropriate legal description. Each Survey shall contain the surveyor's certification to Buyer, Seller, and the Title Company that (i) the Survey was made on the ground; (ii) there are no visible or recorded easements, discrepancies, conflicts, encroachments, or overlapping of improvements except as shown on the Survey; (iii) the Survey correctly shows all visible or recorded easements or rights of way across the Real Property or any other easements or rights of way of which the surveyor has been advised, including, without limitation, those matters affecting title reflected in the Title Commitment; (iv) the Survey correctly shows the location of all buildings, structures, and other improvements situated on the Real Property; (v) the Survey conforms to all applicable minimum guidelines for surveys of comparable property as set forth in applicable laws, regulations, or professional standards; (vi) all streets abutting the Real Property and all means of ingress to and egress from the Real Property have been completed, dedicated, and accepted for public maintenance by the relevant municipal body; (vii) except as shown thereon, the Real Property is not located within the 100 year flood plain or other flood hazard area; (viii) the Survey is a true, correct, and accurate representation of the Real Property; and (ix) such other matters as may be required by the Title Company to allow it to issue the Title Policy.

5.19. [Conversion of Non-Profit JVs. Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its respective representatives and counsel to cooperate with, the other party to take all necessary, proper or advisable actions to consummate the conversion of each of the Non-Profit JVs into for-profit entities. Upon the consummation of each such conversion, the new for-profit entity shall be referred to herein as a "**Converted Venture**."]

6. ADDITIONAL COVENANTS

6.01. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment

Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five (5) years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies maintained by such party. In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense, any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to cooperate with, the other party after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this Section shall not unreasonably interfere with the conduct of business of the other party and nothing in this Section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) Buyer agrees to abide by all applicable laws relating to the confidential information it acquires. Buyer agrees to maintain the patient records delivered to Buyer at the Closing at the Hospital Businesses after Closing in accordance with applicable Legal Requirements (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. §1395(v)(l)(i)), the privacy and security requirements of HIPAA, including, but not limited to, the Administrative Simplification subtitle of HIPAA, and applicable state requirements with respect to medical privacy and security and requirements of relevant insurance carriers, all in a manner consistent with the maintenance of patient records generated by the Hospital Businesses after the Closing.

6.02. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed 120 days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller and its Wholly Owned Subsidiaries relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior

to the Closing limited powers of attorney (on behalf of itself and its Wholly Owned Subsidiaries, as applicable) substantially in the form of Exhibit B hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall indemnify and hold harmless Seller and its Wholly Owned Subsidiaries, and their officers, trustees and employees for all claims, liabilities and costs arising from or relating to use of such licenses and registration after the Closing Date.

6.03. Noncompetition. Seller hereby covenants that at all times from the Closing Date until the fifth (5th) anniversary of the Closing Date, Seller and its Affiliates shall not, directly or indirectly, except as a member, consultant, or contractor to or of Buyer (or any Affiliate of Buyer), own, lease, manage, operate, control, or participate in any manner with the ownership, leasing, management, operation, or control of any business that offers services in competition with the Hospital Businesses, including but not limited to any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a thirty (30) mile radius of the Hospital (the "**Restricted Area**"), without Buyer's prior written consent (which Buyer may withhold in its sole and absolute discretion); *provided, however*, that (i) Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates through the Hospital: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services provided by Buyer, and (ii) Seller and its Affiliates will not be precluded from participating in activities that are otherwise described in Schedule 6.03 of this Agreement. In the event of a breach of this Section 6.03, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Seller and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section 6.03 form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section 6.03. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

6.04. Allocation of Purchase Price; Cooperation on Tax Matters.

(a) Within a reasonable time after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospital Businesses and the Assets. Such allocation will be in accordance with Section 1060 of the Code. Buyer's proposed allocation will become final and binding on the parties 45 days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within 60 days after Seller gave its objection to Buyer. If a final resolution is not reached within 60 days after Seller has submitted its objection in writing, each of Buyer and Seller shall make their own independent allocation of the total consideration among the Hospital Businesses and the Assets. If Seller and Buyer reach agreement upon the allocation (or Seller does not object to Buyer's proposed allocation), Seller and Buyer will be bound by the agreed allocation and (for federal and state Tax purposes) account for and report the transactions contemplated by this Agreement in accordance with such allocation, and will not voluntarily take any position (whether in Tax Returns, Tax audits or other Proceedings) inconsistent with such allocation. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the IRS in accordance with such allocation.

(b) Following the Closing, the parties shall cooperate fully with each other and shall make available to the other, as reasonably requested and at the expense of the requesting party, and to any taxing authority (to the extent required by Legal Requirements), all information, records, or documents in their possession relating to the Assets, the Hospital Businesses, and the Assumed Liabilities as is reasonably necessary for the preparation and filing of any Tax Return, claim for refund of Taxes, or other filings relating to Taxes, or in connection with any audit or other proceeding instituted by any taxing authority. In the case of any audit, examination, or other proceeding with respect to Taxes for which Seller is or may be liable pursuant to this Agreement, Buyer shall promptly inform Seller, and Buyer shall execute or cause to be executed powers of attorney or other documents necessary to enable Seller to take all actions reasonably deemed necessary by Seller with respect to such audit, examination, or proceeding to the extent such audit, examination, or proceeding may affect the amount of Taxes for which Seller is liable pursuant to this Agreement. Seller shall have the right to control any such audit, examination, or proceeding, and, if there is a reasonable basis therefor, to initiate any claim for refund, file any amended return, or take any other action that it deems appropriate with respect to such Taxes.

6.05. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can execute or cause to be

executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

6.06. Seller's Cost Reports. Seller, at its expense, shall prepare and timely file all terminating and other cost reports required or permitted by law to be filed under the Government Payment Programs or other third party payor programs and the State Health Agency for periods ending on or prior to the Closing Date, or as a result of the consummation of the transactions described herein (the "**Cost Reports**"). Buyer shall provide Seller with access to all records and data necessary for completion of Cost Reports. Buyer shall forward to Seller any and all correspondence relating to Cost Reports within five (5) business days after receipt by Buyer. Buyer shall remit any receipts of funds relating to Cost Reports within ten (10) business days after receipt by Buyer and shall forward to Seller any demand for payments within five (5) business days after receipt by Buyer. Seller shall retain all rights to the Cost Reports including any amounts receivable or payable in respect of such reports or reserves relating to such reports. Such rights shall include the right to appeal any determinations by Government Payment Programs relating to Cost Reports. Seller shall retain the originals of Cost Reports, correspondence, work papers and other documents relating to Cost Reports; *provided, however*, that Seller shall make certain that the Hospital Businesses retain copies of such Cost Reports, correspondence, work papers and other documents in order that they are available to Buyer following the Closing Date.

6.07. Continuation of Hospital and Post-Care Continuum. For a period of at least five (5) years after Closing, Buyer (i) will continue to provide at the Hospital Businesses essential clinical and other services described on Exhibit C, and (ii) will not merge, dissolve, consolidate, sell or otherwise dispose of the Hospital without the consent of Seller or its designee (other than to an Affiliate of Buyer or PMH); *provided, however*, that this clause (ii) shall not prohibit Buyer from entering into or engaging in (x) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or that relates to a broader group of facilities or assets than the Hospital, or (y) any corporate-level transactions involving PMH's assets, stock or securities, including mergers, recapitalizations or reorganizations.

6.08. Sale of Hospital Within Three Years. In the event of a sale of all of the Hospital Businesses for cash, whether by merger, sale, or other transaction, at any time prior to the third (3rd) anniversary of the Closing, for a purchase price in excess of (a) the Purchase Price paid by Buyer for the Assets, *plus* (b) the amount of any expenditures made by Buyer or its Affiliates with respect to the Hospital Businesses and their affiliated businesses in the Greater Waterbury region in such period, *plus* (c) any losses generated by the Hospital Businesses and its affiliated businesses in such period (such amount, the "**Net Hospital Value**"), then Buyer agrees to convey to Seller or its designee immediately upon closing of such transaction by wire transfer of immediately available funds in an amount equal to twenty percent (20%) of the difference

between (i) the Net Hospital Value and (ii) the cash purchase price paid to Buyer in connection with such subsequent sale transaction. Notwithstanding anything to the contrary this Section shall not apply to (x) any sale required by a Governmental Authority, (y) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or relates to a broader group of facilities or assets than the Hospital Businesses, or (z) any corporate-level transactions involving PMH's stock or securities, including mergers, recapitalizations or reorganizations.

6.09. Charity Care and Community Obligations. Seller has historically provided significant levels of care for indigent and low-income patients. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will ensure that the Hospital maintains and adheres to Seller's current policies on charity care, attached as Schedule 6.09 for at least five (5) years from Closing. During all times that Buyer owns and operates the Hospital, Buyer will operate the Hospital's charity care program in accordance with Legal Requirements, and will continue to provide medically necessary services to the surrounding communities served by Seller. For a period of at least five (5) years after the Closing, Buyer shall (i) participate in the Medicare and Medicaid programs and accept all Medicare and Medicaid patients, (ii) accept all emergency patients without regard to ability to pay, (iii) maintain an open medical staff; (iv) provide public health programs of educational benefit to the community, and (v) generally promote public health, wellness, and welfare to the community by operating the Hospital with quality standards consistent with other hospitals owned by PMH, subject, in each case, in all respects to changes in governmental law, policy or regulation.

6.10. Capital Commitment. After the Closing, Buyer agrees to spend or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) not less than the Capital Amount in the seven (7) years following the Closing Date on capital projects, including routine and non-routine capital expenditures, at, or for the benefit of, the Hospital Businesses and/or the acquisition, development and improvement of hospital, ambulatory or other health care services in the greater Waterbury, Connecticut community, and which shall include, for the avoidance of doubt, expenditures relating to the implementation of PMH's coordinated regional care model (CRCM) and Physician Recruitment Expenditures. Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed after Closing that (i) discriminates against, or adversely or disproportionately affects for-stock or for-profit hospitals or other for-profit health care entities or (ii) causes Buyer to suffer a material decline in EBIDTA on a consolidated basis, then, in either event, Buyer shall be relieved of its obligation to provide the above capital commitment and shall be required to consult with the Local Board to determine an alternate mutually agreeable capital commitment of Buyer that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.

6.11. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements or in order to coordinate the defeasance of tax-exempt debt, Seller (and its Affiliates and Wholly Owned Subsidiaries) and Buyer (and its Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the

transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party.

(b) At all times before and after the Closing, Seller, on the one hand, and PMH and Buyer, on the other hand, will consult with the other before issuing or making any reports, statements or releases to the public with respect to this Agreement or the transactions contemplated by this Agreement and will use good faith efforts to obtain the other party's prior approval of the text of any public report, statement or release to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements, then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

6.12. Local Board. After Closing, Buyer shall form a local community advisory board comprised of between nine (9) and twelve (12) members (the "**Local Board**"). The Local Board shall include as members thereof the following individuals who shall serve in an *ex officio* capacity: (a) Chief of Medical Staff and (b) Head of Clinical Quality. In addition, a member of the board of directors of Buyer shall serve as a member of the Local Board and shall be selected to serve in such capacity by the board of directors of Buyer. The Local Board shall, among other things, (i) make recommendations and suggestions to Buyer regarding the mission, vision and value statements with respect to the Hospital and the Hospital Businesses; (ii) make recommendations and suggestions with respect to medical staff credentialing, disciplinary action of staff physicians, and compliance with accreditation requirements; (iii) provide input on policies and clinical programs; (iv) provide input in the development and review of strategic plans; (v) provide input on operating and capital budgets; (vi) provide input and support physician recruitment efforts; (vii) provide input on succession plans for executive leadership at the Hospital; (viii) promote community health initiatives, fostering community relationships and identifying service and education opportunities; and (ix) monitor the commitment to maintain and improve quality indicators.

6.13. Misdirected Payments, etc. Seller and Buyer covenants and agrees to remit, with reasonable promptness, to the other any payments received, which payments are on or in respect of accounts or notes receivable owned by (or are otherwise payable to) the other. In addition, and without limitation, in the event of a determination by any governmental or third-party payor that payments to Seller or the Hospital Businesses resulted in an overpayment or other determination that funds previously paid by any program or plan to Seller or the Hospital Businesses must be repaid, Seller shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered on or prior to the Closing Date, and the Buyer shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered after the Closing Date. In the event that, following Closing, the Buyer suffers any offsets against reimbursement under any third-party payor or reimbursement programs due to Buyer, relating to amounts owing under any such programs by Buyer or any of its Affiliates,

Seller shall immediately upon written demand from the Buyer pay to the Buyer the amounts so billed or offset.

6.14. Medical Staff Matters. Buyer shall adopt current bylaws and hearing procedures and otherwise work together with the Local Board and medical staff of the Hospital to preserve the existing staff membership and the current privileges of each physician, as well as the medical staff leadership.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

Notwithstanding anything herein to the contrary, the obligations of Seller to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Seller at the Closing:

7.01. Representations; Warranties. Each of the representations and warranties of Buyer contained in this Agreement that is qualified as to materiality was true and correct in all respects when made and shall be true and correct as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date, and each of the representations and warranties of Buyer contained in this Agreement that is not qualified as to materiality was true and correct in all material respects when made and shall be true and correct in all material respects as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Buyer on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

7.02. Governmental Matters. All material consents, authorizations, orders, and approvals of (or filings or registrations with) any Government Authority or other party required in connection with the execution, delivery, and performance of this Agreement shall have been obtained or made by Buyer when so required, except for any documents required to be filed, or consents, authorizations, orders, or approvals required to be issued, after the Closing Date.

7.03. Actions; Proceedings. No Proceeding before a court or any other Government Authority, unless resolved, shall have been instituted or threatened to restrain or prohibit the transactions herein contemplated, and no Government Authority shall have taken any other action or made any request of any party hereto as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

7.04. Insolvency. Buyer shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated a bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Buyer.

7.05. Closing Documents. All Closing Documents required to be delivered to Seller pursuant to Article 9 shall have been delivered to Seller.

8. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

Notwithstanding anything herein to the contrary, the obligations of Buyer to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Buyer at the Closing:

8.01. Representations; Warranties. Each of the representations and warranties of Seller contained in this Agreement that is qualified as to materiality was true and correct in all respects when made and shall be true and correct as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date, and each of the representations and warranties of Seller contained in this Agreement that is not qualified as to materiality was true and correct in all material respects when made and shall be true and correct in all material respects as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Seller on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

8.02. Pre-Closing Confirmations. Buyer shall have obtained documentation or other evidence satisfactory to Buyer in their sole discretion that Buyer has:

(a) Received satisfactory approval from all Government Authorities whose approval is required to complete the transactions herein contemplated (including, without limitation, satisfactory approvals, with conditions acceptable to Buyer in its sole discretion, of the applications to the Attorney General and Commissioner of Public Health of the State of Connecticut relating to the sale of the Assets by Seller to Buyer and/or any other projects or activities in the community that Buyer, in its reasonable discretion, deems necessary as a predicate for the transactions contemplated herein);

(b) Received confirmation from all applicable licensure agencies that, upon the Closing, either (i) all Permits required by law to operate the Hospital Businesses as currently operated will be transferred to, or issued or reissued in the name of, Buyer, or (ii) Buyer will be permitted to operate the Hospital Businesses as currently operated from and after the Closing until such time as all appropriate Permits are issued or reissued in the name of Buyer;

(c) Obtained reasonable assurances that Medicare and Medicaid certification of the Hospital Businesses, including the Hospital, for their operation by Buyer will be effective as of the Closing and that Buyer may participate in and receive reimbursement from such programs effective as of the Closing;

(d) Reasonably assured itself that all waiting periods under the HSR Act have been terminated or expired and that any additional approvals required from the Justice Department and/or the FTC relating to the transactions contemplated herein have been obtained and are in form and substance satisfactory to Buyer in its reasonable discretion;

(e) Obtained reasonable assurances that the material grants and grant programs listed on Schedule 8.02(e) shall continue after the Closing; and

(f) Obtained such other consents and approvals as may be legally or contractually required for the consummation of the transactions described herein.

8.03. Actions; Proceedings. No Proceeding before a court or any other Governmental Authority, unless resolved, shall have been instituted to restrain or prohibit the transactions herein contemplated, and no Governmental Authority shall have taken any other action or made any request of any party hereto as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

8.04. Adverse Change. Since the date hereof, no event or condition has occurred or exists that could reasonably be expected to cause a Material Adverse Effect.

8.05. Insolvency. Seller shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated a bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Seller.

8.06. Consents to Assignments. Consents (including consents to assignments), waivers, and estoppels of third parties, for those certain contracts and leases set forth on Schedule 8.06 from the counterparties to such contracts and leases, shall have been obtained, received by Buyer, and are in form and substance reasonably satisfactory to Buyer.

8.07. Vesting; Recordation. Seller shall have furnished to Buyer, in form and substance satisfactory to Buyer, assignments or other instruments of transfer and consents and waivers by others, necessary or appropriate to transfer to and effectively vest in Buyer all right, title, and interest in and to the Assets, in proper statutory form for recording if such recording is necessary or appropriate.

8.08. Due Diligence Investigation. Buyer shall have completed the due diligence investigation of the Hospital Businesses and the Assets, and the results of such investigation shall have been found satisfactory to Buyer in its sole and absolute discretion. **[Note: Assuming that the Agreement is executed at or near the time of closing, when the due diligence investigation will have been completed, Section 8.08 can be deleted.]**

8.09. Title Insurance Policies and Surveys. Buyer has received the Title Policy and the Surveys.

8.10. Loan Agreement. The Loan Agreement shall have been satisfied, discharged and terminated and all Encumbrances created by or in connection with the Loan Agreement shall have been released.

8.11. Waterbury Hospital Cash Balance Retirement Plan. Seller shall have taken all steps necessary to freeze the Waterbury Hospital Cash Balance Retirement Plan (the "**Cash Balance Plan**") effective as of the Closing Date so that no benefits, other than those required pursuant to a collective bargaining agreement, will accrue for any participant in the Cash

Balance Plan after the Closing Date, including providing any notice of such freeze as required under applicable laws.

8.12. Closing Documents. All Closing Documents required to be delivered to Buyer pursuant to Article 9 shall have been delivered to Buyer.

9. CLOSING; TERMINATION OF AGREEMENT

9.01. Closing.

(a) Consummation of the sale and purchase of the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at [_____] at 10:00 a.m. on the third (3rd) business day following satisfaction or waiver of the conditions to Closing set forth in Article 7, 8 and 9, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 9.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 9.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, PMH.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and Seller shall deliver (or cause to be delivered) to Buyer control and possession of the Assets.

9.02. Action of Seller at Closing. At the Closing, Seller shall deliver to Buyer:

(a) Special Warranty Deed, fully executed by Seller in recordable form, conveying to Buyer good and marketable fee title to the Owned Real Property, and Assignment and Assumption of Leases, fully executed by Seller in recordable form, assigning to Buyer leasehold title to the Leased Real Property, in each case subject only to current Taxes not yet due and payable as of the Closing Date and the Permitted Encumbrances;

(b) A General Assignment, Conveyance, and Bill of Sale, fully executed by Seller, conveying to Buyer good and marketable title to all tangible assets that are a part of the Assets and valid title to all intangible assets that are a part of the Assets,

free and clear of all liabilities, claims, liens, security interests, and restrictions other than the Assumed Liabilities and the Permitted Encumbrances (the "**Bill of Sale**");

(c) An Assignment and Assumption Agreement, fully executed by Seller, conveying to Buyer Seller's interest in the Assumed Contracts (the "**Assignment and Assumption Agreement**");

(d) All instruments, documents, and affidavits required by the Title Company to issue the Title Policy as described in and provided by Section 5.17 hereof that are consistent with the Connecticut Standards of Title;

(e) the Transitional Services Agreement, fully executed by Seller;

(f) Copies of resolutions duly adopted by the Board of Trustees of Seller, authorizing and approving the performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and of full force as of the Closing, by the appropriate officers or other representatives of Seller;

(g) A certificate of the President or a Vice President of Seller certifying that each covenant and agreement of Seller to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of Seller is true and correct on the Closing Date, as if made on and as of the Closing;

(h) Certificates of incumbency for the officers or representatives of Seller executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(i) Certificates of existence of Seller from the state in which it is incorporated, dated the most recent practical date prior to the Closing;

(j) All Certificates of Title and other documents evidencing an ownership interest conveyed as part of the Assets, including all JV Interests;

(k) An affidavit stating that Seller is not a "foreign person" as defined in Section 1445(f)(3) of the Code, as amended;

(l) All necessary state and local real estate conveyance Tax forms duly executed by Seller;

(m) Final execution copy of the Transfer Act Form III and ECAF, as more fully described in Section 5.06;

(n) Limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers, in substantially the form of Exhibit B attached hereto, fully executed by Seller; and

(o) Such other instruments and documents as Buyer reasonably deems necessary to effect the transactions contemplated hereby.

9.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) The Purchase Price due to Seller (less the Indemnification Holdback Amount) as adjusted in accordance with Section 2.05;

(b) Copies of resolutions duly adopted by the Board of Directors of PMH and Buyer authorizing and approving the performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and in full force as of the Closing, by the appropriate officers of PMH and Buyer;

(c) A certificate of the President or a Vice President of Buyer certifying that each covenant and agreement of Buyer to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of Buyer is true and correct on the Closing Date, as if made on and as of the Closing;

(d) A certificate of incumbency for the respective officers of PMH and Buyer executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(e) Certificates of existence and good standing of Buyer from the state in which Buyer is formed or incorporated, dated the most recent practical date prior to Closing;

(f) Such other instruments and documents as Seller reasonably deems necessary to effect the transactions contemplated hereby;

(g) The Transitional Services Agreement, fully executed by Buyer;

(h) Final execution copy of the Transfer Act Form III and ECAF with a $3,000 filing fee[12], as more fully described in Section 5.06; and

(i) Such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this Agreement.

9.04. Termination Prior to Closing.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller, if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Article 8; (iii) by Seller, by written notice to Buyer, if any event occurs or condition exists that causes Buyer to be

[12] Under review

unable to satisfy one or more conditions to the obligations of Seller to consummate the transactions contemplated by this Agreement as set forth in Article 7; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before [_____] (*provided, however*, that, Buyer shall have the right, exercisable upon prior written notice to Seller, to extend such date by up to an additional thirty (30) days if all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied other than the receipt of approvals from all governmental authorities whose approval is required to complete the transactions herein contemplated, but only if Buyer is diligently pursuing such remaining governmental approvals or contesting in good faith any of the terms or conditions of such approvals, including, without limitation, pursuing any changes in respect of the conditions imposed on the operation of the Hospital or the related businesses or any other modifications set forth in such approval); *provided, however*, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; or (v) by Buyer, pursuant to Section 5.08.

(b) If this Agreement is validly terminated pursuant to Section 9.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 9.04(a), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity, (ii) the termination fee provisions of Section 9.04(d), the expense allocation provisions of Section 11.21 and the confidentiality provisions of Section 6.11 shall remain in full force and effect and survive any termination of this Agreement.

(c) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing.

(d) In the event that this Agreement is terminated by:

(i) Buyer for any reason other than pursuant to Section 9.04(a)(ii) or Section 9.04(a)(iv);

(ii) by Seller pursuant to Section 9.04(a)(iii) due to the occurrence of any event or existence of any condition that causes Buyer to be unable to satisfy the conditions to the obligations of Seller to consummate the transactions

contemplated by this Agreement as set forth in Sections 7.01, 7.04 or 7.05 (*provided,* that, with respect to Section 7.05, all closing conditions have been satisfied or waived, other than the conditions that by their terms are to be satisfied by actions to be taken at the Closing, provided that such actions are, as of the time of such termination, capable of being satisfied at the Closing); or

(iii) by Seller pursuant to Section 9.04(a)(iv) and at the time of such termination (x) all the conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Section 8 have been satisfied (other than the conditions that by their terms are to be satisfied by actions to be taken at the Closing, provided that such actions are, as of the time of such termination, capable of being satisfied at the Closing), and (y) Seller is in compliance in all material respects with the terms of this Agreement,

then Buyer shall, within five (5) business days after receipt of written notice of such termination, pay to Seller by wire transfer of immediately available funds to an account designated by Seller a fee equal to One Million Dollars ($1,000,000) (the "**Termination Fee**").

(e) This Section 9.04 shall survive any termination of this Agreement.

10. INDEMNIFICATION

10.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent provided in this Article 10, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any inaccuracy in or breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof;

(b) any claim asserted against Buyer or Buyer's Affiliates that, if meritorious, would constitute or give rise to a breach of any of Seller's representations and warranties as the direct cause of such claim;

(c) the nonfulfillment or breach of any covenant of Seller set forth in this Agreement or in any Closing Document to which Seller is a party;

(d) the Excluded Liabilities; and

(e) any claim made by a third party with respect to the operation of the Hospital Businesses prior to the Closing Date.

10.02. Seller's Limitations. Seller will have no liability under Section 10.01(a) and no claim will accrue against Seller under Section 10.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 10.01(a) exceeds $150,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's

Indemnified Persons shall be entitled to indemnification for all Losses under Section 10.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Seller shall arise for all Losses, in respect of Losses resulting from Seller's intentional misrepresentation or fraud, *provided, further*, that Seller's liability for indemnification under Section 10.01(a) shall be limited to an amount equal to $3,000,000.

10.03. Indemnification by Buyer. Subject to the conditions and limitations, and solely to the extent, provided in this Article 10, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) the inaccuracy in or breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof;

(b) the nonfulfillment or breach of any covenant of Buyer in this Agreement or in any Closing Document to which Buyer is a party;

(c) the Assumed Liabilities; and

(d) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing Date.

10.04. Buyer's Limitations. Buyer will have no liability under Section 10.03(a) and no claim will accrue against Buyer under Section 10.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 10.03(a) exceeds $150,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 10.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Buyer, *provided, further*, that Buyer's liability for indemnification under Section 10.03(a) shall be limited to an amount equal to $3,000,000.

10.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this Article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 10 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a reasonable summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and

related materials) to the Indemnifying Party within 60 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in this Section 10.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided, further*, that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 10.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more of Buyer's Indemnified Persons and one or more of Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical

rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of Section 10.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided, however*, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld or delayed) and (B) the out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates).

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within 60 days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 60-day period in which to respond pursuant to Section 10.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be attempted to be resolved pursuant to Section 11.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within 10 days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 11.19.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 10.05(a)(i) and Section 10.05(b)(i), as applicable.

10.06. Survival of Representations and Warranties; Indemnity Periods. All of the representations, warranties, covenants, and agreements made by the parties in this Agreement or pursuant hereto in any certificate, instrument, or document shall survive the consummation of the transactions in the manner described herein, and may be fully and completely relied upon by Seller, Buyer, and PMH, as the case may be, notwithstanding any investigation heretofore or hereafter made by any of them or on behalf of any of them, and shall not be deemed merged into any instruments or agreements delivered at the Closing or thereafter. Each party acknowledges that no representations or warranties are made except as specifically set forth herein. Notwithstanding anything in this Section 10.06 that may be to the contrary, any claim, demand, or cause of action with respect to a breach of any representation or warranty made in this Agreement (other than representations or warranties contained in Sections 3.01 (Organization and Qualification), 3.02 (Corporate Powers; Absence of Conflicts, Etc), 3.03 (Binding Agreement), 3.04 (Investments and Third Party Rights), 3.10 (Title), 3.28 (Joint Ventures), 4.01 (Organization), 4.02 (Power and Authority; Due Authorization), 4.03 (Consents; Absence of Conflicts, Etc.), 4.04 (Due Execution; Binding Agreement), which shall survive indefinitely, and the representations or warranties contained in Sections 3.05 (Legal and Regulatory Compliance), 3.12 (Environmental Laws), 3.16 Government Payment Programs; Accreditation; Payor Cost Reports), 3.21 (Employee Benefit Plans), 3.25 (Restricted Assets), and 3.23 (Taxes), which shall

survive the longer of five (5) years or 90 days after the expiration of the applicable statute of limitations pertaining to the underlying claim, including extensions and waivers), must be made or brought, if at all, within eighteen (18) months after the Closing Date. For the avoidance of doubt, this Section 10.06 shall not affect any rights to bring claims after eighteen (18) months based on (a) any covenant or agreement of the parties that contemplates performance after the Closing, (b) the obligations of Seller under Sections 10.01(c), (d) and (e) (Indemnification by Seller), (c) the obligations of Buyer under Sections 10.03(b), (c) and (d) (Indemnification by Buyer), or (e) the obligations of the parties under Section 10.07 (Mitigation).

10.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any Third Party Claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

10.08. Calculation of Losses. Solely for the purpose of calculating the amount of any Losses arising out of or resulting from any breach of any representation or warranty contained in this Agreement (and not for determining the existence of any breach of any representation or warranty contained in this Agreement), any reference to a "material", "materiality" or "Material Adverse Effect" or other correlative terms in such representation or warranty shall be disregarded.

10.09. Indemnification Holdback.

(a) Buyer shall be entitled to apply against the Indemnification Holdback Amount any unpaid amounts due to Seller pursuant to Section 2.05(h).

(b) The Buyer's Indemnified Persons shall be entitled to be reimbursed from the Indemnification Holdback Amount for any Losses arising from Section 10.01, and from time to time during the three (3) year period immediately following the Closing Date, on not less than ten (10) days' notice to Seller, Buyer (or PMH) shall be entitled to apply some or all of the Indemnification Holdback Amount if and to the extent any of the Buyer's Indemnified Persons incur any Losses under Section 10.01.

(c) Any Indemnification Holdback Amount remaining following the three (3) year period identified in Section 10.09(a), and subject to the last sentence of this Section 10.09(b), shall be released, with simple interest thereon, which interest shall accrue at a rate equal to four percent (4%) per annum from the Closing Date (as if the amount of such Indemnification Holdback Amount being released to Seller had been fixed at Closing), to Seller within thirty (30) days following the applicable survival date set forth in Section 10.06 ("**Indemnification Holdback Survival Date**") by wire transfer of immediately available funds to such account or accounts of Seller as Seller specifies in writing to Buyer in the manner specified herein for the delivery of notices. Notwithstanding the terms of the preceding sentence, if Buyer has submitted a notice for indemnification or other Losses exist on or prior to the Indemnification Holdback Survival Date and such indemnification claim is not finally determined until after the Indemnification Holdback Survival Date, a portion of such remaining Indemnification Holdback Amount that, in the reasonable judgment of Buyer, is sufficient to satisfy any shortfall amounts under Section 2.05(h) or any potential unsatisfied claims or Losses (including, if applicable, reasonable attorney's fees) shall be retained by Buyer until such shortfall amounts, claims or Losses, as applicable, have been resolved and shall not be released as provided above until after such shortfall amounts are paid, such indemnification claim shall have been finally determined or such Losses shall have been finally quantified and any indemnification payments (through application of funds from the remaining Indemnification Holdback Amount) to Buyer or any Buyer's Indemnified Persons, as applicable, have been made.

(d) For clarity, in no event shall the Indemnification Holdback Amount be deemed to be in any respect a cap on (i) the amount of any shortfall which Buyer shall be entitled to apply against the Indemnification Holdback Amount pursuant to Section 2.05(h) and Section 10.09, or (ii) the amount of any Losses for which the Buyer's Indemnified Persons shall be entitled to recover pursuant to Section 10.01 and Section 10.09.

11. GENERAL

11.01. Exhibits; Schedules. Each Exhibit and Schedule to this Agreement shall be considered a part hereof as if set forth herein in full.

11.02. Equitable Remedies. Each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the

availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 10).

11.03. Other Owners of Assets. Buyer, Seller and its undersigned Wholly Owned Subsidiaries acknowledge that certain Assets may be owned by Wholly Owned Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Wholly Owned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Wholly Owned Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Wholly Owned Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Wholly Owned Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement.

11.04. Dispute Resolution. The parties hereby agree that, prior to pursuing any other legal remedy, any controversy or claim arising out of this Agreement shall be attempted to be resolved through the following procedures:

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party written notice of such dispute pursuant to Section 11.14, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 11.04(a) within 30 days of the written notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within 15 days after receipt of written notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

11.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions

provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

11.06. Reproduction of Documents. This Agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

11.07. Consented Assignment. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Assumed Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller shall cooperate in any reasonable arrangement designed to provide for Buyer the benefits under any such Assumed Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise but shall not be required to commence litigation. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such Assumed Contract, claim or right; *provided, however*, that such obligation shall be of no further force and effect if Seller and Buyer determine that such consent or approval will not be forthcoming.

11.08. Time of Essence. Time is of the essence in the performance of this Agreement, *provided* that, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Manchester, Connecticut are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Waterbury, Connecticut are permitted or required to be closed. The parties will use commercially reasonable efforts to file as soon as practicable and pursue all necessary regulatory approvals required in connection with this Agreement.

11.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

11.10. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or

any other jurisdiction). Any litigation or proceedings among the parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

11.11. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate one or more Affiliates to purchase any or all of the Assets, including the Hospital Businesses, provided that PMH shall unconditionally guarantee any and all obligations of such Affiliates pursuant to Section 11.22, and (ii) Buyer and PMH shall be permitted to grant a security interest in and collaterally assign and transfer all their rights, interests and benefits, but not their obligations, under this Agreement to any entity providing financing to Buyer and/or Buyer's Affiliates at any time and from time to time without obtaining the written consent of Seller.

11.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms (except as otherwise provided in Section 5.03(d)).

11.13. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by the other party of any provision of this Agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this Agreement, or (c) any other right or remedy permitted the waiving party in this Agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by the party entitled to the benefit of the provision, condition, right or remedy to be waived, and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies.

11.14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) three (3) days after the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: c/o Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd.. Suite 400
Los Angeles, CA 90025
Attn: General Counsel
Fax: 310-943-4501
Email: ellen.shin@prospectmedical.com

with a copy to (which shall not constitute notice):

Epstein Becker & Green, P.C.
1 Gateway Center
Newark, NJ 07102
Attn: Gary W. Herschman
Email: GHerschman@ebglaw.com
Attn: David E. Weiss
Email: DWeiss@ebglaw.com

If to Seller: Greater Waterbury Health Network, Inc.
Attn: President
Fax: 203-573-6161
Email: dstromstad@wtbyhosp.org

with a copy to (which shall not constitute notice):

Carmody Torrance Sandak & Hennessey, LLP
707 Summer Street, Suite 300
Stamford, CT 06901
Attn: Ann Zucker, Esq.
Fax: 203.252.2686
Email: azucker@carmodylaw.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section.

11.15. Severability. If any provision of this Agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this Agreement would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; (c) the remainder of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this Agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

11.16. CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate Governmental Authority shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

11.17. Entire Agreement; Amendment. Except as set forth in Section 11.21(a), this Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 10.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

11.18. Counterparts; Transmission by Electronic Means. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

11.19. Interest. Any monies required to be paid by any party to another party pursuant to this Agreement shall be due on the date or at the time for payment specified in this Agreement, and monies not paid when due shall accrue interest from and after the due date to, but not including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A. during such period.

11.20. Drafting. No provision of this Agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this Agreement.

11.21. Fees and Expenses.

(a) Except as otherwise expressly set forth in this Agreement and the Letter of Intent, dated April 30, 2015, by and between Seller and PMH, whether or not the transactions contemplated by this Agreement are consummated, (i) Buyer or its Affiliates shall bear and pay all expenses incurred by or on behalf of Buyer in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Agreement and Buyer's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) Seller shall bear and pay all expenses incurred by or on behalf of Seller, or its Affiliates or Wholly Owned Subsidiaries, in connection with the preparation and negotiation of this Agreement and Seller's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than $1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all transfer Taxes, sales and use and similar Taxes arising out of the transfer of the Assets (whether or not originally arising with or assessed to Seller or its applicable Wholly Owned Subsidiary) and (iii) the premium for Buyer's title insurance policies described in Section 8.09.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Agreement and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

11.22. Guarantee of Buyer's Obligations. PMH, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, PMH will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 10.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. PMH obligations under this Section

11.22 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

11.23. Liquidated Damages.

(a) The parties acknowledge that: (i) the agreements contained in Section 9.04(d) are an integral part of the transactions contemplated by this Agreement; (ii) without these agreements, the parties would not enter into this Agreement; (iii) it would be extremely difficult and impracticable, if not impossible, to ascertain with any degree of certainty the amount of damages that would be suffered by Seller in the circumstances in which the Termination Fee is payable; and (iv) the Termination Fee is not a penalty, but rather is liquidated damages in a reasonable amount, negotiated as the parties' reasonable estimate of Seller's damages in the circumstances in which the Termination Fee is payable. Notwithstanding anything to the contrary in this Agreement, Seller's right to receive payment of the Termination Fee pursuant to Section 9.04(d) shall be the sole and exclusive remedy of Seller or any of its Affiliates against Buyer, PMH or any of their respective Affiliates or any of their respective stockholders, partners or members for any and all losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with Section 9.04(d), none of Buyer, PMH or any of their respective Affiliates or any of their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(b) If Buyer fails to pay the Termination Fee pursuant to Section 9.04(d) when due and, in order to obtain such payment, Seller commences a suit or suits that result in a judgment or judgments against Buyer for the Termination Fee, then Buyer shall pay to Seller its costs and expenses (including attorneys' fees and expenses) in connection with such suit and the collection and enforcement of such judgment(s), together with interest on the amount of the Termination Fee from the date such payment was required to be made until the date of payment at the "prime rate" of Bank of America, N.A. in effect on the date such payment was required to be made.

[*Signature Page Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

GREATER WATERBURY HEALTH NETWORK, INC.

By: _____

Title: _____

[BUYER]

By: _____

Title: _____

PROSPECT MEDICAL HOLDINGS, INC.
(only with respect to Section 11.22)

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Wholly Owned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 11.03.

ACKNOWLEDGED BY:

THE WATERBURY HOSPITAL

By: _____

Title: _____

[OTHER ENTITIES]

By: _____

Title: _____

[OTHER ENTITIES]

By: _____

Title: _____

Exhibit A

Form of Transitional Services Agreement

See attached.

Exhibit B

Form of Limited Power of Attorney

See attached.

Exhibit C

Essential Clinical and Other Services

[Comment: To be determined based on diligence]

Buyer shall provide the following essential clinical and other services: (a) Emergency Department/Services (including trauma services), (b) General Medicine, (c) Behavioral Health Services, (d) Inpatient and Outpatient Surgery, (e) Radiology and Diagnostic Services, (f) Obstetrics and Gynecology (including those reproductive services currently provided at the Hospital), (g) Cardiology Services including Open Heart Services, (h) Intensive Care Services, and (i) Neonatal Intensive Care Services (each, an "**Essential Service**"); *provided, however*, that if any of the following contingencies occurs with regard to any particular Essential Service, the Buyer may suspend, terminate, discontinue or materially and substantially modify, limit, or reduce (as applicable) the Essential Service:

(i) The medical staff of the facilities then owned or operated by the Buyer do not include qualified physicians necessary to support the provision of the Essential Service;

(ii) An Essential Service experiences a significant decrease in patient volumes for any reason not within the reasonable control of the Buyer, including technological obsolescence, changes in method, techniques or sites for delivery of the Essential Service, pharmaceutical advancements, failure of the Essential Service to qualify for reimbursement under Medicare (or any successor program) or a material portion of other payors, demographic and other market changes, or other competitive/marketplace factors; or

(iii) The actual or projected volume or clinical staffing for an Essential Service is or will be insufficient to achieve or maintain the level of quality for such Essential Service that is at least equal to, or better than, the level of quality at which the Essential Service is provided at any other general acute care community hospital in the region.

Annex A

Calculation Methodology for Net Working Capital

Schedule 1.02

Persons with "Seller's Knowledge"

[●]	President and Chief Executive Officer
[●]	Senior Vice President and Chief Operating Officer
[●]	Vice President/Chief Financial Officer
[●]	Vice President Medical Affairs/Chief Medical Officer
[●]	Vice President Patient Care/Chief Nursing Officer
[●]	Vice President Information Services/Chief Information Officer
[●]	Chief Medical Information Officer
[●]	Vice President Human Resources
[●]	Director – Compliance and HIPAA
[●]	Assistant Director Finance – Corporate Accounting
[●]	Corporate Compliance Officer
[●]	Administrative Director Facility Operations

Schedule 3.04

[Insert organizational chart with ownership/membership percentages]

EXHIBIT Q3-3

BALANCE SHEET OF PROPOSED TRANSACTION

EXHIBIT Q3-3
BALANCE SHEET FOR THE PROPOSED TRANSACTION

	Balance Sheet as of 8/31/2015 (Ownership Adjusted)	Pro Forma			
		Retained by Surviving Entity	Purchased/ Assumed by Prospect	Purchase Adjustments	Prospect Opening Balance Sheet
Assets					
Current Assets:					
Cash and Cash Equivalents	$ 12,752,652	$ 12,752,652	$ -	$ 10,000,000	$ 10,000,000
Short-term Investments	$ 1,511,197	$ 1,511,197	$ -		$ -
Net Accounts Receivable	$ 34,693,504	$ 124,534	$ 34,568,970		$ 34,568,970
Accts Receivable - Other	$ 4,046,064	$ 3,594,000	$ 452,064		$ 452,064
Inventories	$ 4,016,702	$ -	$ 4,016,702		$ 4,016,702
Prepaid Insurance and Other Expenses	$ 2,774,184	$ 617,654	$ 2,156,530		$ 2,156,530
Due From Affiliates	$ 171,849	$ 171,849	$ -		$ -
Total Current Assets	$ 59,966,152	$ 18,771,886	$ 41,194,266	$ 10,000,000	$ 51,194,266
Noncurrent Assets Who Use Is Limited:					
CHEFA Bond Issue Cost	$ 229,450	$ 229,450	$ -		$ -
Investments	$ 26,778,686	$ 26,778,686	$ -		$ -
Board Designated Funds	$ 3,347,474	$ 3,347,474	$ -		$ -
Loans and Other Receivables	$ 253,069	$ 253,069	$ -		$ -
Funds Held in Trust by Others	$ 44,395,266	$ 44,395,266	$ -		$ -
Goodwill	$ 1,813,567	$ -	$ 1,813,567	$ (1,813,567)	$ -
Net PP&E	$ 31,804,176	$ 2,073,100	$ 29,731,077	$ 1,768,923	$ 31,500,000
Total Assets	**$ 168,587,842**	**$ 95,848,931**	**$ 72,738,910**	**$ 9,955,356**	**$ 82,694,266**
Liabilities					
Current Liabilities					
Accounts Payable and Accrued Expenses	$ (22,759,485.99)	$ (2,831,346)	$ (19,928,139.73)	$ -	$ (19,928,139.73)
Current Portion of Accrued Pension Liablility	$ (3,388,000)	$ -	$ (3,388,000)		$ (3,388,000.00)
Intercompany Liabilities				$ (10,000,000)	$ (10,000,000.00)
Current Portion of Long Term Debt	$ (946,569)	$ (946,569)			$ -
Due to Third-Party Payors	$ (4,946,513)	$ (4,946,513)	$ -		$ -
Total Current Liabilities	$ (32,040,568)	$ (8,724,428)	$ (23,316,140)	$ (10,000,000)	$ (33,316,140)
Long-Term Debt	$ (24,596,339)	$ (24,771,328)	$ 174,989	$ (6,500,000)	$ (6,325,011)
Other Long-Term Liabilities:					$ -
Workers Compensation	$ (12,542,831)	$ (12,542,831)	$ -	0	$ -
Pension	$ (8,997,599)	$ -	$ (8,997,599)	0	$ (8,997,599)
Malpractice	$ (2,013,331)	$ -	$ (2,013,331)	$ 2,013,331	$ -
Asbestos Abatement	$ (2,801,923)	$ -	$ (2,801,923)	0	$ (2,801,923)
Other Long-Term Liabilities	$ (2,042,155)	$ (2,042,155)	$ -		$ -
Total Other Liabilities	$ (52,994,178)	$ (39,356,314)	$ (13,637,865)	$ (4,486,669)	$ (18,124,534)
Total Liabilities	**$ (85,034,746)**	**$ (48,080,742)**	**$ (36,954,004)**	**$ (14,486,669)**	**$ (51,440,674)**
Net Assets	$ 83,553,095	$ 47,768,189	$ 35,784,906	$ (4,531,313)	$ 31,253,593
Net Balance Sheet Items	**$ 168,587,842**	**$ 95,848,931**	**$ 72,738,910**	**$ 9,955,356**	**$ 82,694,266**

EXHIBIT Q4-1

MUTUAL NON-DISCLOSURE AGREEMENT

MUTUAL NON-DISCLOSURE AGREEMENT

THIS MUTUAL NON-DISCLOSURE AGREEMENT ("Agreement") is entered into as of March 9, 2015 (the "Effective Date"), by and among **Prospect Medical Holdings, Inc.** a Delaware corporation, on behalf of and together with its affiliates ("Prospect") and **Greater Waterbury Health Network, Inc.**, on behalf of and together with its affiliates ("GWHN"). (Prospect and GWHN are each referred to herein as a "Party" and collectively as the "Parties").

RECITALS

WHEREAS, the Parties desire to share certain confidential and proprietary information about each other (as defined in Section 1, the "Confidential Information") in order to jointly evaluate potential collaboration options to improve quality and access to care for their patient populations, including, without limitation, a potential affiliation between Prospect and GWHN (the "Proposed Arrangement");

WHEREAS, each Party agrees to keep the Confidential Information it receives from the other Party confidential and not to disclose such Confidential Information, and to be bound by the terms and conditions of this Agreement; and

NOW THEREFORE, in consideration for the mutual exchange of the Confidential Information, the covenants of non-disclosure and confidentiality and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as set forth below:

1. Mutual Exchange of Confidential Information. In connection with their evaluation of the Proposed Arrangement, the Parties have agreed to share certain confidential and proprietary information. Each Party will hold in confidence any and all Confidential Information that it has received from or disclosed to, or will receive from or disclose to, the other Party while reviewing the feasibility of the Proposed Arrangement.

    a. Confidential Information shall include, without limitation, the identity of the Party making the disclosure (the "Discloser"), reports, memoranda, statistics, forms, notes, records, financial information, patient lists, charts, know-how, work-in progress, trade secrets, business methods and processes, legal documents or any other matter relating to the business of any Party (regardless of whether orally, on paper, electronically, or in any other form) or information verbally disclosed ("Confidential Information").

    b. The term "Confidential Information" does not include any such information that is/was: (a) already available or that becomes available to the public through no fault of the receiving Party ("Recipient"); (b) received by Recipient from a third party having a right to disclose it; (c) developed by Recipient independent of any disclosure under this Agreement, as reasonably shown by the Recipient; or (d) approved for release by written authorization of the Discloser.

2. Confidentiality and Non-Disclosure. As a condition to receiving the Confidential Information, each Party agrees to treat the Confidential Information, whether furnished before, on or after the Effective Date, in accordance with the terms and provisions of this Agreement.

3. Persons and Affiliates. As used in this Agreement: (a) the term "person" means any entity, individual or group of individuals, including without limitation, any corporation, company, group, syndicate, or partnership; and (b) the term "affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, a specified person.

4. Use of Confidential Information. Each Party hereto: (a) acknowledges and agrees that all Confidential Information of the other Party shall be deemed confidential and proprietary, shall be treated as such, and shall not be disclosed, either within the Recipient or to a third party, other than in accordance with this Agreement; (b) agrees to use the Confidential Information solely for the purpose of evaluating, negotiating and/or implementing the Proposed Arrangement, and for no other purpose; and (c) agrees not to reproduce the Confidential Information of the other Party in any form, except as necessary for such evaluation, negotiation, or implementation. Each Party agrees that it shall not, without the other Party's prior written consent, disclose such Confidential Information to anyone except its own employees, agents, affiliates, directors and officers, representatives, legal counsel and/or financial advisors, who need such Confidential Information for the purposes set forth above and, who are aware of, subject to, and agree to be bound by, this Agreement. The Recipient shall require and cause any person granted access to the Confidential Information to adhere to the terms of this Agreement and shall be responsible for any breach of this Agreement. Recipient agrees to notify the Discloser in writing as soon as practicable of any misuse or misappropriation of the Confidential Information that comes to the Recipient's attention.

5. Compliance with Laws. Each Party confirms that it will not disclose any Confidential Information in violation of any laws and shall not use the other party's Confidential Information in any manner that would violate any laws.

6. Confidentiality of Negotiations. Each Party agrees that it will not disclose, and will prevent its directors, officers, employees, agents and advisors from disclosing, to any person: (a) that discussions or negotiations are taking place concerning the Proposed Arrangement; or (b) any of the terms, conditions or the facts with respect to the Proposed Arrangement, including the status thereof.

7. Compelled Disclosure. In the event that the Recipient is at any time requested or required (by oral questions, interrogatories, requests for information or documents, subpoena or similar process) to disclose any of the Confidential Information of the Discloser, the Recipient shall provide the Discloser with prompt notice of such request and the documents and/or information requested thereby so that the Discloser may seek an appropriate protective order and/or waive the Recipient's compliance with the provisions of this Agreement. The Parties hereto further agree that, if in the absence of protective order or the receipt of a waiver hereunder, the Recipient reasonably believes, based on the written advice of counsel, that it is nonetheless compelled to disclose any

Confidential Information of the Discloser to any tribunal or governmental body, the Recipient may disclose to such tribunal or governmental body without liability hereunder that portion of such Confidential Information that it is compelled to be disclosed; provided, however, that the Recipient shall give the Discloser written notice of the information to be so disclosed as far in advance of its disclosure as practicable and shall use its reasonable best efforts to obtain an order or such reliable assurance that confidential treatment will be accorded to such portion of the information required to be disclosed as the Discloser designates.

8. Return or Destruction of Confidential Information. Upon the request of either Party hereto, the other Party: (a) shall promptly return to the requesting Party or destroy all Confidential Information of the requesting Party and all written materials containing or reflecting any information contained in such Confidential Information; and (b) shall not retain any copies, extracts or other reproductions in whole or in part of such written material. All documents, memoranda, notes and other writings whatsoever based on the information in the Confidential Information requested to be returned shall be destroyed by the Party in possession thereof, and such destruction shall be certified in writing to the requesting Party. Notwithstanding anything to the contrary in this Agreement, the Parties shall not be required to return or destroy copies of any computer records or files containing Confidential Information which have been created pursuant to automatic archiving and back-up procedures and which cannot reasonably be returned or destroyed. The retention, return, or destruction of such materials, as applicable, shall not relieve the Parties hereto of their respective confidentiality, non-disclosure, and non-use obligations hereunder.

9. No Implied Rights. Except as expressly set forth herein, this Agreement shall not confer upon either Party, or be a basis for implying, any rights of any kind in the Confidential Information of the other Party.

10. Waiver and Amendment. No failure or delay by a Party in exercising its rights hereunder shall operate as a waiver or preclude any further or other exercise of such rights. No provision of this Agreement may be waived or amended unless such waiver or amendment is in writing, designated as a waiver or amendment to this Agreement, and if an amendment, signed by both Parties. This Agreement constitutes the entire agreement of the Parties with respect to the subject matter hereof.

11. Equitable Remedies. The Parties agree that owing to the nature of this Agreement and the Confidential Information, money damages would not be a sufficient remedy for any breach of this Agreement and that either Party shall be entitled to specific performance and injunctive and/or other equitable relief as a remedy for any such breach by the other Party. Each Party hereby consents to any such remedy and further agrees to waive any requirement for the securing or posting of any bond in connection with such remedy. Such remedy shall not be deemed to be the exclusive remedy for breach of this Agreement, but shall be in addition to all other remedies available at law or equity. If any legal action relating to this Agreement is brought by a Party against another Party, the prevailing Party shall be entitled to recover its reasonable costs, expenses, and attorneys' fees.

12. No Warranty. Neither Discloser nor any of its representatives makes, or shall be deemed to have made, any representation or warranty, express or implied, as to the accuracy or

completeness of any Confidential Information disclosed pursuant to this Agreement, and neither Discloser nor any of its respective representatives shall have any liability to Recipient arising out of or resulting from any use of the Confidential Information or any errors or omissions that may be contained therein.

13. Notices. Notices or communications required or permitted to be given under this Agreement shall be given to the respective Parties by hand or by registered or certified mail (said notice being deemed given as of the date of mailing) at the following addresses unless a Party shall otherwise designate its address by notice:

If to Prospect:

Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025
Attention: Legal Department

If to GWHN:

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, CT 06721
Attn: President and Chief Executive Officer

With a Copy to:

Ann H. Zucker, Esq.
Carmody Torrance Sandak & Hennessey LLP
707 Summer Street
Stamford, CT 06901

14. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut.

15. Counterparts. This Agreement may be executed in one or more counterparts, and by facsimile signatures, each of which shall be an original document, and all of which together shall constitute one and the same instrument.

16. Term; Termination. This Agreement will terminate upon the later of one (1) year from the effective date or when all confidential information has been returned to each respective Discloser. The parties' duties of confidentiality with respect to the other party's Confidential Information shall extend for four years after the termination or expiration of this Agreement.

[Signature Page Follows.]

IN WITNESS WHEREOF, the Parties hereby execute this Agreement on the above Effective Date.

PROSPECT MEDICAL HOLDINGS, INC.

By: _____

Its: VICE PRESIDENT, CORP DEVELOPMENT

GREATER WATERBURY HEALTH NETWORK, INC.

By: Darlene Stromstad

Its: President and Chief Executive Officer

{NS070995}

EXHIBIT Q4-2: CONSULTING AGREEMENT

EXECUTION VERSION

INTERIM CONSULTING AGREEMENT

THIS INTERIM CONSULTING AGREEMENT (this "Agreement") is made and entered into as of the 27 day of October, 2015 (the "Effective Date") by and between Prospect Medical Holdings, Inc., a Delaware corporation ("Prospect," and collectively with its Affiliates (as defined below), "Advisor"), and Greater Waterbury Health Network, Inc., a Connecticut non-stock corporation ("GWHN").

RECITALS

A. GWHN, together with its Affiliates (collectively, the "Company"), operates The Waterbury Hospital (the "Hospital") which serves the needs of residents of the greater Waterbury, Connecticut area.

B. On April 30, 2015, Advisor entered into a Letter of Intent with the Company, as amended by that certain Amendment No. 1 to Letter of Intent dated August 28, 2015, by that certain Amendment No. 2 to Letter of Intent dated September 10, 2015, and by that certain Amendment No. 3 to Letter of Intent dated September 14, 2015 (as so amended, the "Letter of Intent") which sets forth certain terms and conditions pursuant to which Advisor, or an Affiliate of Advisor, would acquire the businesses of the Company pursuant to the terms of a definitive Asset Purchase Agreement to be negotiated and entered into by GWHN and Advisor, the form of which is being filed in connection with the parties' application for CON Approvals (as defined below) (the "Purchase Agreement"). Defined terms used but not defined herein shall have the meanings set forth in the Letter of Intent. References contained herein to Sections and Section numbers of the Purchase Agreement shall be deemed to refer to any successor provisions thereto, as the case may be.

C. The Letter of Intent provides, among other things, that the term of the Letter of Intent shall continue in effect until the earlier of (x) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the Letter of Intent, (y) one hundred eighty (180) days following the receipt by the parties of the certificate of need approval for the Hospital by the Office of Healthcare Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Office of the Attorney General of the State of Connecticut (the "CON Approvals"), subject to Prospect's right to extend the Letter of Intent term up to an additional one hundred eighty (180) days if Prospect is diligently contesting in good faith any of the terms or conditions of such CON Approvals (as set forth in greater detail in the Letter of Intent).

D. The Purchase Agreement is expected to set forth various conditions to Closing (including regulatory approvals), but pursuant to Connecticut law, the Purchase Agreement cannot be executed by the parties until receipt of the CON Approvals. Furthermore, even after the Purchase Agreement is executed, the various conditions (including regulatory approvals) to Closing set forth therein may take months to satisfy or obtain.

E. Given the contracting restrictions imposed upon the parties by the State of Connecticut, the parties seek to confirm in writing that this Agreement is intended to continue until the closing of the transactions contemplated in the Letter of Intent (and, more specifically,

in the Purchase Agreement) and that should this Agreement terminate, Advisor shall be entitled to be paid its Consulting Service Fees (as defined below) in accordance with, and to the extent provided by, Section 6.5 hereof.

F. Advisor, through its executives and other personnel, has certain experience and expertise in the management, operations, financial and administrative aspects of businesses like that of the Company.

G. Advisor is willing to provide certain consulting services, as described on Exhibit A hereto (the "Consulting Services"), with the objective of improving and otherwise benefitting the operations of the Company and the Hospital during the time period from the Effective Date through the Closing of the Purchase Agreement, pursuant to the terms and conditions contained in this Agreement.

H. The Company seeks to confirm in writing Advisor's agreement to provide the Company with the Consulting Services between the Effective Date and the Closing Date (unless this Agreement is sooner terminated in accordance with the provisions of Article VI below).

NOW, THEREFORE, in consideration of the premises and mutual covenants set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and for their mutual reliance, the parties agree as follows:

ARTICLE I
RECITALS; AFFILIATES

1.1 Recitals. The recitals set forth above are hereby incorporated into this Agreement as if fully set forth in this Article I.

1.2 Affiliate. As used herein, "Affiliate" means, as to GWHN or Prospect, any person or entity that directly or indirectly controls, is controlled by, or is under common control with, as applicable, GWHN or Prospect and any successors or assigns of such person or entity; and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of, as applicable, GWHN or Prospect whether through ownership of voting securities, by appointment of trustees, directors, and/or officers, by contract or otherwise.

ARTICLE II
CONSULTING SERVICES

2.1 Services. For and during the Term (as defined in ARTICLE V below) for the consideration set forth below, Advisor shall provide the Consulting Services with respect to the operation of the Hospital and other programs and services carried on by the Company (collectively, the "Business") described on Exhibit A, as it may be amended from time to time, upon the terms and conditions as set forth herein.

2.2 Delivery. The Consulting Services, as and when delivered or rendered hereunder, will be performed by personnel having the requisite skills and experience required to provide the Consulting Services on a timely basis, and will be performed in a prompt, professional and

workmanlike manner in accordance with all applicable professional standards and best practices in the industry. Advisor reserves the right to initially determine which of its personnel shall be assigned to perform Consulting Services and to replace or reassign such personnel during the term hereof. The Company, however, shall pre-approve the Advisor employees assigned to work on the Consulting Services, but such approval will not be unreasonably withheld. Advisor further agrees that, following advice received from the Company, Advisor will remove from the Consulting Services any employee or contractor to whom the Company has reasonable objection.

2.3 Maintenance of Control. The Consulting Services entail recommendations to the Company regarding how to improve the operations and financial condition of the Company's Business. The Company agrees to consent to make operational changes recommended by Advisor unless in the reasonable business judgment of the executive leadership of the Company such consent is not warranted in the circumstances. Nothing in this Agreement is intended to alter, weaken, displace or modify the authority of either (i) the Board of Trustees of the Company with respect to the ultimate oversight and governance of the Company, or (ii) the executive leadership of the Company with respect to the Business and the assets and affairs of the Company. During the Term, the Board of Trustees of the Company shall exercise ultimate authority, supervision, direction and control over the business, policies, operation and assets of the Company, and shall retain the ultimate authority and responsibility regarding the powers, duties and responsibilities vested in the Board of Trustees of the Company by any and all applicable laws and regulations. The parties mutually acknowledge and agree that any Consulting Services provided pursuant to this Agreement are intended to constitute assistance and support to the Company's Board of Trustees and executive leadership, and are not intended and shall not be construed to grant Advisor any rights or interests in, nor decision-making authority with respect to, the Company or the Business, and the rights and interests of Advisor shall be limited to those expressly set forth herein or in the Purchase Agreement, if and when executed. In furtherance of the foregoing, the Company's Chief Executive Officer shall determine the priority, timing and delivery of the projects included in the Consulting Services and may direct Advisor to redirect its efforts among such projects.

2.4 Input Into Company's Strategic Business Decisions. The Company, through its Chief Executive Officer, shall make Advisor aware of key strategic business decisions facing the Company and shall elicit input from Advisor on said decisions, and Advisor shall respond promptly, knowledgably and in the best interests of the Company.

2.5 Consulting Services Fee. In connection with its receipt of Consulting Services pursuant to this Agreement, the Company shall pay to Advisor one (1%) percent of the Company's net patient revenue, as reported in the consolidated financial statements of GWHN, per month (cumulatively, the "Consulting Services Fee"). If the Closing under the Purchase Agreement takes place, payment of the Consulting Services Fee shall be waived, and in the event the Closing does not take place, then payment of the Consulting Services Fee shall be paid in accordance with the provisions of Section 6.5 hereunder.

2.6 Company's Commitments. The Company shall provide Advisor with sufficient working space and other reasonable physical accommodations at the Facilities as appropriate to the Consulting Services, including access to telephones, facsimile machines, internet connections and copiers, to enable Advisor to fulfill its duties and responsibilities hereunder. The Company

and its management staff shall provide timely responses to Advisor's requests for information (and other inquiries) to enable Advisor to perform the Consulting Services hereunder, and shall fully cooperate with Advisor in the fulfillment of Advisor's duties hereunder, including, without limitation, attending meetings and providing information, feedback and input to Advisor.

2.7 Liaisons. Advisor shall direct all inquiries regarding the Consulting Services, and provide all recommendations, reports and other matters relating to the Consulting Services, to Darlene Stromstad, the Company's Chief Executive Officer, and/or such person(s) as she may from time to time designate. The Company shall direct all inquiries regarding the Consulting Services to Von Crockett at Prospect and/or such person(s) as he may from time to time designate.

2.8 Access of Advisor; Patient Records.

(a) During the Term, Advisor shall be given complete access to the Company's records (including Patient Records as defined below), offices and Facilities, in order that it may carry out its obligations hereunder, subject to the confidentiality requirements relating to Patient Records and Confidential Information (as defined below).

(b) The Company shall maintain, to the fullest extent of the law, sole and exclusive responsibility for the preparation, storage and destruction of all patient medical records, clinical treatment plans, charts and similar documents generated in connection with the operation of the Business (collectively, the "Patient Records"). The Company shall assure that the Patient Records are prepared in compliance with all applicable federal, state and local laws and regulations. All Patient Records will be maintained by the Company and shall remain the property of the Company.

(c) To the extent permitted by law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the standards or regulations promulgated thereunder, including the Privacy Standards and the Security Standards, as well as the federal Health Information Technology for Economic and Clinical Health Act (including any and all standards and regulations promulgated thereunder) and professional ethics regarding confidentiality and disclosure of medical information, the Company shall make such information available to Advisor to enable Advisor to perform its duties hereunder and for any and all other reasonable purposes. For the purposes of this Section 2.8, Advisor shall be referred to as the Company's Business Associate ("Business Associate"). As a Business Associate, Advisor agrees to enter into the Business Associate Agreement with the Company, attached hereto as Exhibit B.

ARTICLE III
[RESERVED]

ARTICLE IV
CONFIDENTIALITY; PROPRIETARY RIGHTS

4.1 Due to the highly competitive nature of the health care industry, disclosure of certain nonpublic, confidential or proprietary information – including but not limited to

Advisor's Proprietary Rights (as defined below), the Company's Proprietary Rights (as defined below), analyses, compilations, summaries, memoranda, studies, policy and procedure documentation/information, quality assurance materials or other documents prepared by the Company or Advisor in connection with this Agreement or the Consulting Services provided hereunder (collectively, the "Confidential Information") – would be extremely damaging to the party that owns or has the right to such Confidential Information. The parties therefore agree to maintain the confidentiality of the other party's Confidential Information and to protect as a trade secret any portion of the other party's Confidential Information by using reasonable efforts to prevent any unauthorized disclosure, copying, use, distribution, or transfer of possession of such Confidential Information. Each party agrees to maintain at least the same procedures regarding the other party's Confidential Information that it maintains with respect to its own Confidential Information, but in no event less than a reasonable standard of care. For purposes of this Agreement, Confidential Information shall not be deemed to include information and data: (a) rightfully previously known or acquired by either party from a third party without a continuing restriction on use; (b) that is or becomes a part of the public domain through no breach of this Agreement by either party; (c) approved for release by written authorization by the party who owns or has rights to the Confidential Information; (d) that is required to be disclosed and made public by law; or (e) independently developed by either party.

4.2 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to Advisor and its Affiliates learned, acquired or obtained by the Company and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of Advisor or its Affiliates, employed or obtained by Advisor or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which Advisor or any of its Affiliates has any interest (collectively, "Advisor's Proprietary Rights") are proprietary to Advisor and shall remain the property of Advisor or its Affiliates and are not, at any time during the Term or thereafter, to be utilized, distributed, disseminated, copied or otherwise employed or acquired by the Company, any of the Company's Affiliates, or their respective officers, directors, trustees, consultants, members, employees, shareholders, and agents, except as authorized by Advisor in writing. To the extent that such Proprietary Rights are embodied in the Consulting Services or the implementation of the recommendations of the Consulting Services, the Company shall have the perpetual, nonexclusive right to use such materials for its own operations, which rights shall survive the termination or expiration of this Agreement.

4.3 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to the Company and its Affiliates learned, acquired or obtained by Advisor and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of the Company or its Affiliates, employed or obtained by the Company or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which the Company or any of its Affiliates has any interest (collectively, "Company's Proprietary Rights") are proprietary to the Company and shall remain the property of the Company or its Affiliates and are not, at any time during the Term or thereafter, to be utilized,

distributed, disseminated, copied or otherwise employed or acquired by Advisor, any of Advisor's Affiliates, or their respective officers, directors, trustees, contractors, members, employees, shareholders, and agents, except as authorized by the Company in writing.

4.4 Each party acknowledges that the breach of the provisions of this ARTICLE IV would cause irreparable injury to the non-breaching party that could not be adequately compensated by money damages. Accordingly, the non-breaching party may obtain a restraining order, injunction or other equitable relief prohibiting a breach or threatened breach of the provisions of this ARTICLE IV without the necessity of posting any bond or security whatsoever, in addition to any other legal or equitable remedies that may be available. In the event of a breach or threatened breach by either party of any of its obligations under this ARTICLE IV, the other party shall have the right, in addition to any other remedies that may be available to it, to obtain specific performance of the terms of this Agreement without posting any security or bond whatsoever.

4.5 If requested by court order or other legal process to disclose any information constituting Confidential Information, Advisor's Proprietary Rights or Company's Proprietary Rights, the party so requested shall promptly give notice of such request or requirement to the other party so that such party may, at its own cost and expense, seek an appropriate protective order or, in the alternative, waive compliance to the extent necessary to comply with such request if a protective order is not obtained. If a protective order or waiver is granted, the party to whom the request was made may disclose such information only to the extent required by such court order or other legal process or to the extent permitted by such waiver.

4.6 The provisions of this ARTICLE IV shall survive the termination of this Agreement, provided, however, this provision shall terminate upon the Closing of the Purchase Agreement. In that event, however, the parties shall continue to be subject to the terms and conditions of that certain Confidentiality Agreement dated as of March 9, 2015, which shall remain in full force and effect in accordance with its terms.

ARTICLE V
TERM

The term of this Agreement shall commence on the Effective Date and shall continue until the Closing of the Purchase Agreement (the "Term"), unless sooner terminated in accordance with the provisions of ARTICLE VI below.

ARTICLE VI
TERMINATION

6.1 Termination by Either Party For Cause. If either party materially defaults in the performance of any material covenant, agreement, term or provision of this Agreement or the Letter of Intent to be performed by it and such material default continues for a period of thirty (30) days after written notice is delivered to the breaching party from the other party stating the specific default, then the non-breaching party may terminate this Agreement by giving written notice thereof to the breaching party; provided, however, that the non-breaching party shall not have the right to terminate under this Section 6.1 at the end of such thirty (30) day period so long

as the breaching party has commenced a cure within such thirty (30) day period and thereafter diligently pursues such cure to completion, which shall be no later than sixty (60) days after the initial written notice.

6.2 Termination Upon Bankruptcy, Etc. If either party shall apply for or consent to the appointment of a receiver, trustee or liquidator for it or for all or substantially all of its assets, file a voluntary petition in bankruptcy or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or any answer seeking reorganization or arrangement with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by a court of competent jurisdiction, on the application of a creditor, adjudicating either party to be bankrupt or appointing a receiver, trustee or liquidator of either party with respect to all or substantially all of the assets of either party, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days, then this Agreement shall automatically terminate.

6.3 Termination Upon Dissolution of the Company, Termination of Letter of Intent or Termination of Purchase Agreement. This Agreement shall terminate immediately and automatically upon the first to occur of the following events:

(a) the Company or Advisor files for voluntary dissolution;

(b) the Letter of Intent expires by its terms or is otherwise terminated; and

(c) the Purchase Agreement is terminated (in accordance with the provisions thereof) prior to a Closing of the transactions contemplated therein.

6.4 Regulatory Matters. If the performance by either party of any material covenant, agreement, term or provision of this Agreement would (a) result in the de-certification of a Hospital under any federal or state government program or by any other regulatory agency that would have a material adverse effect on the operation of the Business, (b) result in the loss of a Hospital's accreditation, or (c) be in violation of any statute or regulation, or for any other reason be or become illegal and such violation or illegality would have a material adverse effect on the operation of the Business, and in any such event, the reason therefore cannot be corrected by good faith negotiations and effort of the parties hereto within sixty (60) days after written notice thereof (with the objective of keeping the financial intent of the parties hereunder materially the same), then either party may at its option terminate this Agreement.

6.5 Certain Rights Upon Termination.

(a) In the event of any of the following:

(i) upon written notice by Advisor to GWHN, where GWHN has materially breached the exclusivity provisions of Section 14 of the Letter of Intent;

(ii) upon the receipt of the CON Approvals, if (x) Advisor has executed a purchase agreement with substantially the same economic terms as are contained in the Purchase Agreement but (y) GWHN fails to execute such purchase

agreement (without good reason) within ten (10) days after Advisor's execution thereof; or

(iii) the parties having both executed a purchase agreement with substantially the same economic terms as are contained in the Purchase Agreement, if (x) all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied by Advisor, but GWHN fails to close the transactions pursuant to Section 9.01 of the Purchase Agreement, or (y) GWHN breaches its obligations under Section 5.11(a) of the Purchase Agreement;

then, Advisor shall be paid by GWHN, within 30 days after such termination and receipt of an invoice therefor, any accrued and unpaid Consulting Service Fees. For the avoidance of doubt, in all other events, including in the event a Closing occurs under the Purchase Agreement, Advisor shall not be entitled to receive any Consulting Service Fee hereunder.

(b) The right to terminate this Agreement, and to receive payment of any amounts owing as of the effective date of termination, shall be in addition to any other remedy available pursuant to the provisions hereof. The termination of this Agreement for any reason shall be without prejudice to any payments or obligations that may have accrued or become due hereunder prior to the effective date of termination or that may become due after such termination.

6.6 Cessation of Use of Proprietary Rights Upon Termination. Upon termination of this Agreement, each party shall immediately discontinue the use of, and shall promptly return to the other party, as applicable, all Confidential Information (to the extent in tangible format) that was made available to such party by reason of its participation in this Agreement, including any copies that it may have in its possession or control.

6.7 Failure to Terminate. Failure to terminate this Agreement shall not waive any breach of this Agreement.

6.8 Survival. To the extent expressly set forth or contemplated in this Agreement, provisions of this Agreement shall survive the termination of this Agreement.

ARTICLE VII
LIABILITY, INDEMNIFICATION, PROFITABILITY AND INDEPENDENT CONTRACTOR

7.1 Limitation of Liability. Except for Advisor's gross negligence or willful misconduct, Advisor shall not by reason of this Agreement or any Consulting Services rendered pursuant to this Agreement have any liability in connection with the operation of the Business or be deemed to have assumed any liabilities associated with or incident to the operation of the Business. Without limiting the generality of the foregoing, Advisor shall have no liability for any breach of any obligation under this Agreement unless such breach shall constitute gross negligence or willful misconduct; it being understood that in such case of a breach of an obligation that does not constitute gross negligence or willful misconduct, the Company's sole remedies shall be to obtain damages pursuant to Section 15.1 below and/or to terminate this Agreement as provided herein.

7.2 Indemnification.

(a) The Company hereby agrees to defend, indemnify and hold harmless Advisor and its Affiliates, and their respective officers, directors, contractors, members, employees, shareholders, agents, successors and assigns (each, an "Advisor Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Advisor Indemnified Party arising out of or resulting from (i) any breach by the Company of any of its representations, warranties, covenants, obligations or duties under this Agreement or (ii) the Company's gross negligence or willful misconduct.

(b) Advisor hereby agrees to defend, indemnify and hold harmless the Company, and its Affiliates, and their respective officers, directors, trustees, contractors, members, employees, shareholders, agents, successors and assigns (each a "Company Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Company Indemnified Party arising out of or resulting from (i) any breach by the Advisor of any of its representations, warranties, covenants, obligations or duties under this Agreement, or (ii) Advisor's gross negligence or willful misconduct.

(c) The provisions of this Section 7.2 shall survive the termination of this Agreement.

7.3 No Representation of Profitability, Etc. Advisor does not guarantee or represent that operation of the Business will be profitable, or have a certain amount of revenues or cash flow. Except as otherwise expressly provided herein, Advisor shall not be liable for the Company's losses, whether from operation of the Business or otherwise.

7.4 Independent Contractor Status. Advisor does not under this Agreement act in any capacity other than as an independent contractor and does not, under this Agreement, act as principal in the operation of the Business, the Hospital or any other facilities of the Company.

ARTICLE VIII
NON-SOLICITATION

8.1 Covenant Not To Solicit. During the Term and for a period of two (2) years after the Term (the "Non-Solicit Period"), each party shall not, and shall cause its Affiliates not to, directly or indirectly, (a) take any action that may induce any customer, employee, agent, contractor, or vendor of the other party (either individually or in the aggregate) to discontinue his, her or its affiliation with such other party, or (b) solicit or hire the employees or independent contractors of the other party or any Affiliate thereof without the prior written consent of such other party.

8.2 Equitable Relief. In the event of a breach or threatened breach by a party or any of its Affiliates of any of the obligations under this ARTICLE VIII, the other party shall be entitled, upon application to any court of proper jurisdiction, to a temporary restraining order or

preliminary injunction to restrain and enjoin the breaching party and/or its Affiliates from such violation without prejudice as to any other remedies the non-breaching party may have at law or in equity. Each party agrees that, in the event of a violation by such party or an Affiliate thereof, it would be virtually impossible for the other party to calculate its monetary damages and that such other party would be irreparably harmed. If the non-breaching party seeks a temporary restraining order or preliminary injunction, such non-breaching party shall not be required to post any bond or other security with respect thereto, or, if, nonetheless, a bond is required, it may be posted without surety thereon. If any restriction contained in this ARTICLE VIII is held by any court to be unenforceable, or unreasonable, as to time, geographic area or business limitation, the parties agree that such provisions shall be and are hereby reformed to the maximum time, geographic area or business limitation permitted by applicable laws. The parties further agree that the remaining restrictions contained in this ARTICLE VIII shall be severable and shall remain in effect and shall be enforceable independently of each other. Each party specifically acknowledges, represents and warrants that the covenants set forth in this ARTICLE VIII are reasonable, necessary, and enforceable to protect the legitimate interests of the other party, and that such other party would not have entered into this Agreement in the absence of such covenants.

ARTICLE IX
REPRESENTATIONS AND WARRANTIES

9.1 Of Advisor. Advisor represents and warrants to the Company as follows:

(a) Advisor has been duly organized and validly exists as a corporation in good standing under the laws of the State of Delaware, with full corporate power to own its properties and to conduct its business under such laws.

(b) Advisor has the full corporate power and authority to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authorization, execution, delivery and performance of this Agreement by Advisor have been duly taken. The individual executing this Agreement on behalf of Advisor is duly authorized and has the requisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by Advisor under this Agreement, nor compliance by Advisor with any provision of this Agreement will conflict with or violate Advisor's articles of incorporation or bylaws, any agreements to which Advisor is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon Advisor's execution of this Agreement, this Agreement shall constitute a valid and binding obligation of Advisor, enforceable in accordance with its terms.

(e) Neither Advisor, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, or (iii) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

9.2 Of the Company. The Company represents and warrants to Advisor as follows:

(a) The Company has been duly organized and validly exists as a nonstock corporation in good standing under the laws of the State of Connecticut, with full limited power to own its properties and to conduct its business under such laws.

(b) The Company has the full corporate power and authority as a company to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authorization, execution, delivery and performance of this Agreement by the Company have been duly taken. The individual executing this Agreement on behalf of the Company is duly authorized and has the requisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by the Company under this Agreement, nor compliance by the Company with any provision of this Agreement will conflict with or violate the Company's articles of incorporation, bylaws, any agreements to which the Company is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon the Company's execution of this Agreement, this Agreement shall constitute a valid and binding obligation of the Company, enforceable in accordance with its terms.

(e) Neither the Company nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, or (iii) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

ARTICLE X
INSURANCE

10.1 Advisor's Required Coverage. During the Term hereof, Advisor shall maintain, at its own expense, workers' compensation coverage in accordance with statutory requirements for Advisor's employees who provide services under this Agreement, and commercial general liability insurance in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. The limits above may be satisfied by any combination of self insurance or umbrella policies, and Advisor may carry any insurance required by this Agreement under a blanket policy. Company shall be an additional named insured under the Advisor's general liability policy.

10.2 The Company's Required Coverage. The Company shall maintain, at the Company's expense, at all times during the Term: (a) workers' compensation coverage in accordance with statutory requirements for the Company's employees; (b) commercial property damage and fire/hazard insurance written on full replacement value basis for all of the Company's assets and real property; (c) professional liability insurance covering the Company's employees who perform any work, duties, or obligations against claims for bodily injury, death,

malpractice and property damage, which insurance shall provide coverage on a claims-made or occurrence basis with a per occurrence limit of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate; and (d) comprehensive commercial general liability insurance in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate. The above limits may be satisfied by any combination of primary and excess or umbrella policies. The Company may carry any insurance required by this Agreement under a blanket policy. Advisor shall be an additional named insured under the Company's general liability insurance policy.

10.3 Certificates of Insurance. On the Effective Date and at any time upon request, each party shall provide the other party certificates of insurance evidencing the coverages required hereby, and shall notify the other party immediately of the cancellation, termination, or non-renewal of, or material change in, such insurance coverage.

ARTICLE XI
ARMS-LENGTH BARGAINING

The parties agree that the compensation provided herein has been determined in arm's-length bargaining and is consistent with fair market value in arm's length transactions and is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to the Hospital or other facilities of the Company or between the parties or any of the undersigned persons or equity holders thereof for which payment may be made in whole or in part under Medicare or any state health care program or under any other payor program.

ARTICLE XII
ASSIGNMENT

Neither party shall, directly or indirectly, assign or otherwise transfer this Agreement, or any interest herein or obligation hereunder, without the prior written consent of the other party, which may be withheld in such other party's sole discretion. In no event may a party assign this Agreement unless the assignee shall have executed and delivered to the other party a written assumption of this Agreement in form and substance satisfactory to such other party in its sole discretion. Notwithstanding the foregoing, Advisor shall be permitted, without the consent of the Company, to assign this Agreement to any Affiliate of Advisor, but Advisor shall remain liable to the Company for the performance and satisfaction of all undertakings and commitments set forth herein.

ARTICLE XIII
NOTICES

All notices required or permitted hereunder shall be given in writing by actual delivery or by certified mail, postage prepaid or by nationally recognized overnight courier service. Notice shall be deemed given upon delivery, or if given by mail, upon receipt or if sent by next day delivery by a nationally recognized overnight courier service, on the next business day. Notice

shall be delivered or mailed to the parties at the following addresses or at such other places as a party shall designate in writing:

If to the Company:	Greater Waterbury Health Network, Inc. 64 Robbins Street Waterbury Hospital Attn: President Fax: 203-573-6161 e-mail: dstromstad@wtbyhosp.org
with a copy (which shall not constitute notice) to:	Carmody Torrance Sandak & Hennessey, LLP 707 Summer Street, Suite 300 Stamford, CT 06901 Attn: Ann Zucker, Esq. fax: 203-252-2682 e-mail: azucker@carmodylaw.com
If to Advisor:	Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard, Suite 400 Los Angeles, CA 90025 Attention: Legal Department
with a copy (which shall not constitute notice) to:	Epstein Becker & Green, P.C. One Gateway Center Newark, NJ 07102 Attention: Gary W. Herschman, Esq. phone: (973) 642-1900 email: gherschman@ebglaw.com Attention: David E. Weiss, Esq. phone: (212) 351-4500 email: dweiss@ebglaw.com

ARTICLE XIV
RECORD ACCESS AND RETENTION

14.1 Access to Records. Each party hereto shall permit, and shall ensure that any subcontractor retained by it permits, the United States Department of Health and Human Services and General Accounting Office, or their authorized representatives, to review appropriate books and records relating to the performance hereunder to the extent required under Section 1861(v)(1) of the Social Security Act, 42 U.S.C. Section 1395x(v)(1)(I), or any successor law or regulation for a period of four (4) years following the last day Advisor provided services hereunder. The access shall be provided in accordance with the provisions of Title 42, Code of Federal Regulations, Part 420, Subpart D.

14.2 Notification. Each party shall notify the other party immediately of the nature and scope of any request for access to books and records described above and shall provide copies of any books, records or documents to the other party prior to the provision of same to any

governmental agent to give such other party an opportunity to lawfully oppose such production of documents. Nothing herein shall be deemed to be a waiver of any applicable privilege (such as the attorney-client privilege) by either party.

ARTICLE XV
MISCELLANEOUS

15.1 Choice of Law; Dispute Resolution; Venue.

(a) Choice of Law. The parties agree that this Agreement shall be governed by and construed in accordance with the Laws of the State of Connecticut, without giving effect to any choice or conflict of law provision or rule thereof that would require the application of any other law.

(b) Dispute Resolution. Except as provided in Section 15.2 below, in the event that any dispute, controversy or claim arises among the parties with respect to this Agreement, including as to the breach, termination or invalidity hereof (a "Dispute"), the parties shall attempt in good faith to resolve such Dispute promptly by negotiation (including at least one in-person meeting) over a period of not less than thirty (30) days, commencing upon one party's delivery of a written notice of Dispute to the other party.

(c) Venue. In the event that any Dispute is not resolved through good faith negotiations as provided in Section 15.1(b) above, either party may submit the matter to a court of law or equity through the filing of a claim. The Parties agree that, except as otherwise expressly provided in Section 15.2 below, venue for any and all claims associated with a Dispute between the Parties shall rest with the state courts of the State of Connecticut.

(d) Waiver of Jury Trial. EXCEPT AS PROVIDED IN SECTION 15.2 BELOW, EACH PARTY HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM (WHETHER BASED ON CONTRACT, TORT OR OTHERWISE) ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

15.2 Injunctive Relief. Notwithstanding anything to the contrary contained herein, each party acknowledges and agrees that a party may seek, from a court of competent jurisdiction in the State of Connecticut, injunctive relief against a breaching party pursuant to Sections 4.4 and 8.2 above, without posting any bond or other undertaking.

15.3 Severability. Should any provision of this Agreement be found void or unenforceable, the remainder hereof nevertheless shall continue in full force and effect. A new provision shall be amended to this Agreement that is similar to the provision found unenforceable but which is enforceable.

15.4 Approval or Consent. Except as otherwise provided herein, whenever under any provisions of this Agreement, the approval or consent of either party is required, such approval or consent shall not be unreasonably withheld, conditioned or delayed.

15.5 Entire Agreement. This Agreement contains the entire agreement between the parties with respect to the subject matter hereof, and the parties expressly agree that this Agreement supersedes and rescinds any prior agreement between them (verbal or written) pertaining to the subject matter hereof.

15.6 No Third Party Beneficiary. Except as expressly provided in this Agreement, no person or entity that is not a party to this Agreement shall be a third party beneficiary of any rights or obligations hereunder or be entitled to enforce any of said rights or obligations.

15.7 Interpretation. The article and paragraph headings contained herein are for convenience of reference only, do not constitute part of this Agreement, and are not intended to define, limit or describe the scope of intent of any provision of this Agreement. All gender references used in this Agreement shall include all genders, and the singular shall include the plural and the plural shall include the singular whenever and as often as may be appropriate.

15.8 Force Majeure. Neither Company nor Advisor shall be deemed to be in violation of this Agreement, and shall not be liable for any resulting claims, losses, damages, expenses and liabilities if it is prevented, hindered or delayed, either directly or indirectly, from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation labor disputes, fires, storms, earthquakes, acts of God, or any statute, regulation or rule of the federal government, any state or local government or any agency thereof.

15.9 Amendments; Course of Dealing. This Agreement may be amended or supplemented only in a writing signed by both parties. The failure of any party to enforce at any time any of the provisions of this Agreement shall in no way be construed to be a waiver of any such provision, nor in any way to affect the validity of this Agreement or any part hereof or the right of any party thereafter to enforce each and every such provision. No waiver of any breach of this Agreement shall be held to be a waiver of any other or subsequent breach.

15.10 Cooperation; Further Assistance. From time to time, as and when reasonably requested by either party hereto, the other party will (at the expense of the requesting party) execute and deliver, or cause to be executed or delivered, all such documents, instruments and consents and will use reasonable efforts to take all such action as may be reasonably requested or necessary to carry out the intent and purpose of this Agreement.

15.11 Execution of this Agreement. The parties may execute this Agreement in counterparts, each of which shall be deemed an original and both of which together shall constitute but one and the same instrument. A signature delivered by facsimile or PDF shall be sufficient for all purposes between the parties.

[*signature page follows*]

IN WITNESS WHEREOF, the parties have executed this Agreement, through their duly authorized representatives, effective as of the date first above written.

ADVISOR:

PROSPECT MEDICAL HOLDINGS, INC., a Delaware corporation

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

THE COMPANY:

GREATER WATERBURY HEALTH NETWORK, INC., a Connecticut non-stock corporation

By:_____
Name: Darlene Stromstad
Title: President

[Signature Page to Interim Consulting Agreement]

IN WITNESS WHEREOF, the parties have executed this Agreement, through their duly authorized representatives, effective as of the date first above written.

ADVISOR:

PROSPECT MEDICAL HOLDINGS, INC., a Delaware corporation

By:_____
Name: Samuel S. Lee
Title: Chief Executive Officer

THE COMPANY:

GREATER WATERBURY HEALTH NETWORK, INC., a Connecticut non-stock corporation

By:_____
Name: Darlene Stromstad
Title: President

[Signature Page to Interim Consulting Agreement]

EXHIBIT A
LIST OF CONSULTING SERVICES

In consideration of the payments to be made hereunder, Advisor shall from time to time and as appropriate provide, either directly or indirectly through one or more of its Affiliates, the following services to the Company:

1. Advise the Company regarding trends in the industry, make recommendations regarding new and/or expanded services and programs, physician alignment & recruitment, IT/EMR capabilities and improvements, technology implementation, ACOs and other reform-driven approaches, and managed care approaches.

2. Review, assess and provide recommendations regarding potential service consolidation and restructurings to achieve efficiencies.

3. Review, assess and provide recommendations regarding new clinical service lines, programs and locations.

4. Review, assess and provide recommendations regarding physician-alignment strategies, joint ventures and other strategic initiatives.

5. Advise the Company regarding expenditure and spending patterns, evaluate standard procurement lifecycle methodologies including working cash vs. discount modeling, invoice synchronization and vendor payment management. Such expenditures and contracts would include without limitation:

    - Third party service providers
    - Supply contracts
    - Contracts with outside contractors or consultants
    - Preventive maintenance with respect to equipment and building
    - Upkeep and maintenance of the physical facilities

6. Advise the Company regarding third- party reimbursement issues and consultation on such issues and compliance with all applicable reimbursement rules.

7. Assist the Company to develop, implement and maintain a compliance program that is committed to promoting, preventing, detecting and resolving instances of conduct that do not conform to federal or state laws.

8. Assist the Company to develop plans with respect to labor relations matters.

9. Review, assess and provide recommendations regarding a physician-led and focused clinical documentation program.

10. Review, assess and provide recommendations regarding the Company's case management program and length of stay initiatives.

11. Assist the Company to develop strategies with respect to cost accounting processes.

12. Provide other Consulting Services as mutually agreed upon in writing by the parties from time to time.

EXHIBIT B
BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into as of the last date of signature (the "Effective Date") by and between Greater Waterbury Health Network, Inc., by and on behalf of its covered entity subsidiaries, affiliates and related organizations (collectively, "Covered Entity"), and Prospect Medical Holdings, Inc., by and on behalf of its business associate subsidiaries, affiliates and related organizations (collectively, the "Business Associate").

R E C I T A L S

Covered Entity and Business Associate have entered into a signed Interim Consulting Agreement and/or other documented arrangement (collectively, the "Consulting Agreement") pursuant to which Business Associate provides services to Covered Entity ("Services") that may require Business Associate to access, create and use health information that is protected by state and/or federal law; and

WHEREAS, the Business Associate is obligated to protect the privacy and security of individually identifiable health information ("Protected Health Information" or "PHI") and electronic protected health information ("EPHI") created and/or maintained by Covered Entity in accordance with the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations at 45 C.F.R. Parts 160 and 164 promulgated by the U.S. Department of Health and Human Services ("HHS"), as amended by the federal Health Information Technology for Economic and Clinical Health Act ("HITECH Act") and its implementing regulations (collectively "HIPAA"); and

WHEREAS, Covered Entity and Business Associate desire to enter into this Agreement in order to comply with HIPAA, as may be modified or amended, including future issuance of regulations and guidance by HHS, and reflect their understanding of the use, disclosure and general confidentiality obligations of Business Associate as it relates to the Consulting Agreement.

NOW, THEREFORE, in consideration of the mutual promises and other consideration contained in this Agreement, the parties agree as follows:

ARTICLE I
DEFINITIONS

Capitalized terms used herein but not otherwise defined in this Agreement shall have the same meanings as set forth in HIPAA, as may be modified or amended, including future issuance of regulations and guidance by HHS.

ARTICLE II
OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

2.1 Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as permitted or required by law.

2.2 Business Associate may use and disclose PHI for the proper management and administration of Business Associate; provided that with respect to any disclosures of PHI, such disclosures are required by law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person. Business Associate may, in accordance with the Privacy Rule, de-identify PHI. Without limitation of the foregoing, Covered Entity acknowledges that the legal structure of the Business Associate and its affiliates, including Prospect Medical Holdings, Inc., affords the Business Associate the opportunity to be characterized for HIPAA purposes as a participant in an affiliated covered entity arrangement as part of such legal structure ("HIPAA Arrangement"), and as such Covered Entity agrees that disclosure of PHI may be made to the other participants in such HIPAA Arrangement and that such other participants in such HIPAA Arrangement may use or disclose PHI, only in compliance with the terms of this Agreement.

2.3 Business Associate agrees to use appropriate physical and technical safeguards to prevent the use or disclosure of Covered Entity's PHI for any purpose other than the provision of Services under this Agreement.

2.4 Upon written request from the Covered Entity, Business Associate agrees to report to Covered Entity, in writing, any use or disclosure of PHI not in compliance with this Agreement.

2.5 In the event Business Associate engages any agent or subcontractor to perform the services under this Agreement and discloses PHI to such agent or subcontractor, Business Associate will require any such agent or subcontractor to agree to the same restrictions and conditions required in this Agreement.

2.6 Upon written request from the Covered Entity, Business Associate agrees to make PHI available to individuals in accordance with 45 CFR Section 164.524 of HIPAA governing access of individuals to PHI.

2.7 Upon written request from the Covered Entity, Business Associate agrees to make PHI available for amendment and incorporate any amendments in accordance with 45 CFR Section 164.526 of HIPAA governing amendments to PHI.

2.8 Upon written request from the Covered Entity, Business Associate agrees to make any and all information available for the purpose of providing patients an accounting of disclosures in accordance with 45 CFR Section 164.528 of HIPAA governing accounting for disclosures.

2.9 Business Associate agrees to make its internal practices, books and records related to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity, available to the Secretary of HHS and the HHS Office for Civil Rights for the purposes of determining Covered Entity's compliance with HIPAA.

2.10 Business Associate shall implement and maintain safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains or transmits on behalf of Covered Entity.

2.11 Business Associate and Covered Entity agree to comply with all applicable rules and regulations promulgated under HIPAA in effect during the term of this Agreement.

2.12 Business Associate will report to Covered Entity within a reasonable time period of discovery, any (a) Security Incident, or (b) Security Breach as defined at 45 C.F.R. Part 164, Subpart D. Business Associate may supplement its initial report as information becomes available in order to identify:

(a) The nature of the non-permitted use or disclosure including how such use or disclosure was made;

(b) The unsecured PHI used or disclosed;

(c) If possible and applicable, the identity of the person/entity who received the unsecured PHI;

(d) What corrective action Business Associate took;

(e) What Business Associate did to mitigate any deleterious effect; and

(f) Such other information as Covered Entity may request.

2.13 At all times during the term of this Agreement, Business Associate will comply with all applicable federal, state and local laws, rules and regulations applicable to business associates and pertaining to patient records and the confidentiality of patient information, including Covered Entity's PHI.

ARTICLE III
OBLIGATIONS OF COVERED ENTITY

3.1 Covered Entity will notify Business Associate of any agreement Covered Entity makes regarding any restriction or requirement for confidential communication with respect to the use or disclosure of PHI, to the extent that such restriction agreement or confidential communication requirement may affect Business Associate's use or disclosure of PHI.

3.2 Covered Entity will: (i) use safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Business Associate, until such PHI is received by

Business Associate; and (ii) inform Business Associate of any consent or authorization, including any changes in or withdrawal of any such consent or authorization, provided to the Covered Entity by an individual.

ARTICLE IV
TERM AND TERMINATION

4.1 This Agreement shall remain in effect until such time as the Consulting Agreement expires or is terminated.

(a) Except for the requirements set forth in Section 4.2, which shall survive as set forth therein, and except as otherwise provided in Section 4.1(b), this Agreement will terminate on the date that the Consulting Agreement is terminated or expires.

(b) This Agreement may be terminated by Covered Entity upon the breach of any material provision of this Agreement by Business Associate, which breach is not corrected within thirty (30) days after written notice of such breach is given to Business Associate. If cure of the breach and termination of this Agreement is not feasible, Covered Entity may report the breach to HHS as required by law.

4.2 Business Associate agrees that, upon termination of the Consulting Agreement and this Agreement, Business Associate will return or destroy all PHI received from or created or received on behalf of Covered Entity. In the event Business Associate determines that return or destruction is not feasible, Business Associate will extend the protections required in this Agreement to the PHI and limit further uses and disclosures to only those purposes that make the return or destruction of the information infeasible.

ARTICLE V
MISCELLANEOUS

5.1 Regulatory References. A reference to HIPAA or the HITECH Act, or a section thereof, and its regulations and requirements means the provisions and section(s) in effect, as may be modified or amended, including issuance of regulations and guidance by HHS.

5.2 Amendment. Both parties agree that the provisions of HIPAA and the HITECH Act, including provisions which apply to business associates and that are required to be incorporated into a HIPAA business associate agreement, are hereby incorporated into this Agreement as if set forth in this Agreement in their entirety and are effective as of the Effective Date. Notwithstanding the foregoing, the parties agree to take such action as is required by law to amend this Agreement pursuant to additional regulations or amendment of HIPAA and the HITECH Act.

5.3 Notices. Any notices to be delivered hereunder shall be delivered to the addresses set forth in and consistent with the requirements for delivery contained in, the Consulting Agreement. Notice shall be in writing and shall be deemed effective when personally delivered

or, if mailed, three (3) calendar days after the date deposited in the United States mail, first class, postage prepaid, to the addressee at its current business address.

5.4 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original and when taken together shall constitute one agreement.

5.5 Choice of Law. All issues and questions concerning the validity, enforcement and interpretation of this Agreement shall be governed by, and construed in accordance with, the laws of the state identified in the Consulting Agreement.

5.6 Voluntary Execution. Each party has read and understands this Agreement, and represents that this Agreement is executed voluntarily and should not be construed against any party hereto solely because it drafted all or a portion hereof.

5.7 Severability. If any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability will not affect any other provision and this Agreement will be reformed, construed, and enforced as if such invalid, illegal or unenforceable provision had never been contained herein.

5.8 No Modification. No modification of this Agreement will be effective unless made in writing and executed by each party hereto, except as otherwise provided hereunder.

5.9 Entire Agreement. This Agreement supersedes any and all prior agreements and understandings between the parties related to the subject matter hereof.

5.10 Independent Contractor. None of the provisions of this Agreement are intended to create any relationship between the parties other than that of independent entities contracting with each other for the purpose of effecting the provisions of this Agreement.

[signature page follows]

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Agreement to be executed and delivered as of the day and year first above written.

COVERED ENTITY:	BUSINESS ASSOCIATE:
GREATER WATERBURY HEALTH NETWORK, INC.	PROSPECT MEDICAL HOLDINGS, INC.
BY: _____	BY: _____
NAME: Darlene Frorstad	NAME: _____
ITS: Pres/CEO	ITS: _____
DATE 10/27/17	DATE: _____

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Agreement to be executed and delivered as of the day and year first above written.

COVERED ENTITY:	BUSINESS ASSOCIATE:
GREATER WATERBURY HEALTH NETWORK, INC.	PROSPECT MEDICAL HOLDINGS, INC.
BY: _____	BY: _____
NAME: _____	NAME: Sam Lee
ITS: _____	ITS: CEO
DATE_____	DATE: 10/27/15

EXHIBIT Q5-1

OFFICE OF HEALTH CARE ACCESS SPECIAL STUDY DN 06-30760-VST

Wtby Hosp
County Hosp

Office of Health Care Access

Report of Investigative Proceedings

Docket Number 06-30760-VST

May 23, 2007

Cristine A. Vogel
Commissioner
Office of Health Care Access

Table of Contents

I. Executive Summary

The health care services provided in the Waterbury area appear to be fragmented, competitive and in financial distress. Although utilization of inpatient and outpatient services is high -- profit margins remain low at both St. Mary's Hospital and the Waterbury Hospital. Access to care is not yet impacted; however, the long-term viability of the health care delivery system is at risk -- presenting an opportunity to restructure and develop an efficient and responsive health care delivery system. After an extensive review of data in this investigation, some of the findings are:

- Saint Mary's Hospital's financial measures indicate that the hospital is insolvent.
- Data suggest that the financial viability of the health system is more sustainable with one hospital and one outpatient system of care.
- Duplication of services is competitive and costly and limits profitability.
- A merger of St. Mary's Hospital and Waterbury Hospital is an option; however, many major issues exist.
- A planned closure of St. Mary's Hospital may be a viable solution providing a pre-determined integration plan is in place.
- Utilization data demonstrate a consistent and steady demand for inpatient and outpatient services will continue in the community.
- A comprehensive primary care system needs to be developed to respond to the immediate need for access which will ultimately improve the hospitals' financial viability and the health status of the community. Data suggest a lack of primary care services exists forcing individuals to utilize the Emergency Department as their health care provider.
- Behavioral health services must be expanded in a comprehensive and cohesive manner.

The financial hardship that St. Mary's Hospital (SMH) and the Waterbury Hospital (WH) struggle with is mostly a result of an economically challenged city. Waterbury experiences a higher rate of uninsured and unemployed compared to the state as a whole and has a lower per capita income. Socioeconomics and demographics play a significant role in the financial condition of hospitals since they rely on philanthropic donations and the balance of government and non-government reimbursement to offset losses.

Additionally, financial hardship can be created when two hospitals are located in close proximity to each other. The expenses related to marketing, advertising, recruitment and retention are increased as each hospital is competing for the most qualified employees and the most profitable patients. Related to the expenses of competition – is duplication. The duplication that exists in the outpatient market results in the thinning out of profitable services so neither organization can leverage the profit. These costs are in addition to those targeted at competing hospitals located in the secondary market. Also

related to competition is the lack of negotiating power the hospitals face during the contracting phase with managed care organizations. Typically the commercial discounts are greater in an area served by two hospitals which decreases the reimbursement from the most lucrative payer source.

This investigation conducted by the Office of Health Care Access (OHCA) was initiated to assess the viability of the health care delivery system in the Waterbury area. Several state agencies have been periodically meeting and discussing the information that OHCA has been collecting. The other state agencies involved are: Department of Public Health (DPH), Department of Social Services (DSS), Office of Policy and Management (OPM), and the Connecticut Health and Educational Facilities Authority (CHEFA).

The purpose of this investigation was to study the socioeconomic factors, utilization of hospitals services and a review of the financial condition of SMH and WH and the impact these factors have on ensuring sustainable access to hospital care in the Waterbury area. Both hospitals have reported negative operating margins for the past two years and have not experienced a strong fiscal year in some time. For Fiscal Year 2006, SMH reported a Total Margin of 0.4% and an Operating Margin of (3.7)%; and WH reported a Total Margin of (2.4)% and an Operating Margin of (3.7)%.

The distressed financial condition of both hospitals, although more severe with SMH, has restricted access to capital for facilities improvement and renovation projects. Both of the hospitals' facilities are aging, they lack sufficient parking, and increasing the capacity to meet demand for services in the Emergency Departments and patient floors has become cost-prohibitive. Thus, occupancy rates are high in many service lines and yet beds, although within licensed bed count, cannot be added.

According to FY06 audited financial statements, St. Mary's Hospital has enough cash to pay one (1) day of its short-term commitments and is taking longer than normal to pay its creditors. Although Waterbury Hospital has more cash on hand and is paying its creditors earlier than prior years, both hospitals are exhibiting the classic symptoms of financial distress.

Each of the findings mentioned above will be further discussed in the Discussion and Conclusions section of this report. All data used in this report can be found in the Findings of Fact section and the Attachments.

II. Summary of Findings

This investigation thoroughly reviewed the socio-economic characteristics, the utilization of services, and the financial challenges of St. Mary's Hospital and the Waterbury Hospital. A detailed analysis of these factors is contained in Attachment A of this report. This summary is provided as an overview of the key factors that contribute to the on-going financial losses of the hospitals.

Socio-economic Characteristics:

Although there are seven towns that best define the "Waterbury Area" included in the investigation, a significant portion of residents who rely on and access St. Mary's Hospital and the Waterbury Hospital for health care services live in the towns of Waterbury, Naugatuck or Watertown. This area consists mostly of:

- young adults who may be full-time students, single, unemployed or have no permanent full-time jobs and therefore, likely to be uninsured;
- a disproportionate share of residents who are over 75 years old and live in the city of Waterbury who maybe inclined to suffer from chronic diseases that need management;
- minorities that have high hospitalization and uninsured rates;
- residents who are less likely to have a college degree or higher, to be skilled professionals or employed;
- a labor force that has a comparably higher tendency to work in service, production, transportation and material moving industries that are seasonal, temporary or part-time in nature;
- people who earn less than the statewide average per capita or household income;
- a population that has a high incidence of hospitalizations that could have been prevented if residents had adequate access to community health services; and
- a federally medically and primary care underserved population.

Utilization:

Utilization data collected in this investigation demonstrated an active use of inpatient and outpatient health care services. There was no significant decline in utilization which in other circumstances would be a reason for a deterioration of financial stability – the Waterbury hospitals show steady volume. This data is summarized for FY 2006 for SMH and WH combined:

- 27,562 Inpatient discharges (remained steady for the past 3 years)
- 116,644 Emergency Department visits (slight increase over the past 3 years)
- 91,684 Medical and Behavioral Health Clinic visits (overall no increase)
- 245,638 Other "outpatient" visits (i.e., surgery, radiology, etc.)

Fundamental system issues exist so although there is steady utilization of services, it is difficult to assess the necessary "size" of the health care system. The Emergency Departments show a higher utilization than typical – probably related to the lack of alternatives available; and each hospital stated the difficulty of discharging certain patients due to an inability to transfer patients to the next level of care.

Combined, the hospital system in the Waterbury area has 704 inpatient beds and 68 bassinets. Over a three-year period, the two hospitals gradually increased the number of staffed beds to 447 or 62% of licensed beds and 68 bassinets. Most of the beds (72% or 323) are for medical/surgical and critical care, 62 beds are for OB/GYN care, 42 beds for psychiatry and 36 beds for pediatric care. Based on the demographic profile of the area, there is excess demand for medical/surgical, critical care and psychiatric beds and insufficient demand for OB/GYN and pediatric beds. Although the high demand have resulted in rather high average occupancy rates (approximately 80%) over the year, the two hospitals have been limited in how many additional beds they can staff because of space constraints, capital costs, staffing shortages or difficulty with discharging patients to the appropriate level of care to a different facility (i.e., skilled nursing, rehabilitation).

Medical care is about one-half of the inpatient care the hospitals provide, surgical and maternity/pediatric care make up one-quarter each and behavioral health care is 5%. While over the three-year period the number of patients discharged increased by only 1%, patient days grew by 5%. With the increases in volumes, the cost of providing care per discharge in the area rose by 20% but growth in revenue did not keep pace with the cost as would be expected, rather loss per discharge more than doubled. Although both hospitals were incurring losses in all inpatient care service lines, larger losses were associated with behavioral health and surgical care. In FY 2006, the loss per discharge (both hospitals combined) in each service line was $2,834 for behavioral health, $1,871 for surgical care, $794 for maternity/pediatrics care and $127 medical care. But loss per service line per discharge varied between the two hospitals, the losses for medical, behavioral health and maternity/pediatric care were lower at St. Mary's Hospital, while the loss per discharge associated with surgical care was lower at Waterbury Hospital. However, some of the differences are explained by what each hospital includes in its components of costs.

The two hospitals combined have 73 Emergency Department (ED) beds and both experience the "boarding" of patients that require admission to an inpatient unit. The hospitals state that staffing, space constraints, and the lack of access to capital constrain their ability to improve through-put of patients in their respective EDs. Approximately 14% of ED visits in the area result in an inpatient admission and like the state and nation account for about one-half of all discharges. As in the case of inpatient services, both hospitals provide ED services at a loss per case.

In the area of medical and dental outpatient care, an affiliate of St. Mary's Hospital provides these services at a loss per visit despite high volumes. An affiliate of Waterbury Hospital provides some outpatient and HIV treatment services and records high volumes but was unable to provide cost data for evaluation. Affiliates of both hospitals also provide outpatient behavioral health clinic services; however, the Waterbury Hospital provides 90% of these services. Loss per visit is almost the same for both facilities, but visits per case to the St. Mary's Hospital behavioral health clinic are three times the visits made to the Waterbury Hospital clinic.

Other outpatient services such as one-day surgery, radiology/imaging, laboratory, gastroenterology and other services are the most profitable services both hospitals provide although the cost at Waterbury Hospital is 1.5 times the cost at St. Mary's Hospital.

The financial instability of both hospitals is not a result of low utilization. The hospitals' combined inpatient discharges for FY06 are 27,562; however, on average the hospitals combined lose $899 per case. In surgical cases, typically a profitable service, the combined hospital loss per case is $1,871. The utilization of the emergency departments is higher than that of the state average which is indicative of a lack of alternative primary health care services. In FY06, the two hospitals reported 116,644 visits to their EDs. This presents a fiscal challenge when 42% of their patients are covered by Medicaid and 10% are uninsured. Of the patients that were treated and discharged (not admitted) from the ED, the hospitals lose a combined $28 per case. This amount of loss per case for such a large volume is difficult to offset since they realize losses in their inpatient services and they have a relatively low reimbursement rate from commercial payers.

Hospital Payer Mix:

When all services are combined (inpatient and outpatient) for both hospitals, commercial payers are the dominant primary payer in the Waterbury Area accounting for 41% of total patient volume. Medicare accounts for 30%, Medicaid for 23% and the uninsured for 4% (Table 1). In fact, commercial payers are the leading primary payer (46%) in the sole profitable areas of service for the hospitals in the "other outpatient services" category, which include medical clinics, one-day surgery, radiology, laboratory, gastroenterology and all other services except ED and outpatient psychiatry. The payer mix varies between services and hospitals. EDs in the area have an unfavorable payer mix with over one-half of their patient volume being either Medicaid-covered or uninsured and an annually declining share of commercially-covered patients. Although both hospitals provide care to a large portion of uninsured patients (9% for St. Mary's Hospital and 11% for Waterbury Hospital), St. Mary's Hospital treats a disproportionate share (49%) of Medicaid patients in the ED. The payer mix presented in Table 1 is highly correlated to the demographic profile outlined in Section 3.0 of Attachment A.

Table 1: Waterbury Area Hospitals Payer Mix by Department, FYs 2004 - 2006

Services	Primary Payer	St. Mary's (2)			Waterbury (2)			Waterbury Area Hospitals (2)		
		FY06	FY05	FY04	FY06	FY05	FY04	FY06	FY05	FY04
Inpatient Discharges	Medicare	42	43	43	44	43	43	**43**	**43**	**43**
	Medicaid	25	23	23	21	20	20	**23**	**22**	**21**
	Commercial	31	32	32	33	34	34	**32**	**33**	**33**
	Worker's Compensation	1	1	1	1	1	1	**1**	**1**	**1**
	Self-pay/uninsured	1	1	1	1	2	1	**1**	**1**	**1**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Emergency Department Treated and Discharged Visits	Medicare	14	15	15	17	18	18	**15**	**16**	**16**
	Medicaid	49	46	43	34	33	32	**42**	**40**	**38**
	Commercial	26	27	29	36	37	37	**30**	**32**	**33**
	Worker's Compensation	2	2	3	3	3	3	**2**	**3**	**3**
	Self-pay/uninsured	9	9	10	11	10	10	**10**	**10**	**10**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Outpatient Behavioral Health Visits	Medicare	9	13	9	46	47	45	**43**	**44**	**42**
	Medicaid	55	58	54	37	35	38	**38**	**37**	**39**
	Commercial	36	28	36	15	16	16	**17**	**17**	**17**
	Worker's Compensation	0	0	0	0	0	0	**0**	**0**	**0**
	Self-pay/uninsured	1	1	0	2	2	2	**2**	**2%**	**2**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
All Other Outpatient Visits	Medicare	32	33	32	30	31	32	**31**	**32**	**32**
	Medicaid	17	17	16	18	18	18	**18**	**18**	**17**
	Commercial	47	47	46	45	45	45	**46**	**46**	**45**
	Worker's Compensation	1	1	3	1	1	1	**1**	**1**	**2**
	Self-pay/uninsured	2	2	3	5	5	4	**4**	**3**	**4**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Total	**Medicare**	**28**	**28**	**28**	**32**	**33**	**33**	**30**	**31**	**31**
	Medicaid	**26**	**26**	**24**	**20**	**19**	**19**	**23**	**23**	**22**
	Commercial	**41**	**41**	**41**	**42**	**42**	**42**	**41**	**42**	**41**
	Worker's Compensation	**2**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	**2**
	Self-pay/uninsured	**4**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	**4**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Financial Indicators:

There is no single financial measure that, by itself, indicates the financial health of or the financial difficulty faced by a hospital. Important indicators to consider are the utilization of services, the payer mix, reimbursement, profit/loss of services, the ability the hospital has to meet its short-term obligations and its access to capital in order to continue to improve facilities and equipment. For consecutive years, both hospitals experienced negative operating margins, also a signal of financial distress.

St. Mary's Hospital's financial performance has deteriorated in the past three (3) years its low current assets to current liabilities ratio, 0.8 in FY06, put the hospital at a higher risk for technical insolvency (below 10th percentile). To improve cash flow, the hospital

shortened the average time it took to collect revenues from billed patients by ten days down to 38 days but that was not enough to improve the average time it took to pay creditors, that increased by a day to 72 days (Table 2).

Waterbury Hospital has experienced deterioration in its cash flows as well. The hospital's days of cash on hand have reduced from 42 days to 20 days, which is below state and national medians. It took the hospital seven days more to collect revenues from billed patients on average, but it paid its creditors five days earlier than it did the year before. Waterbury Hospital is at very low risk of technical insolvency since its current assets to current liabilities ratio in FY06 was 2.03 which is above the median for the state and nation (Table 2).

A serious concern for both hospitals is the difficulties they will have in financing future debt for capital projects. In order for any hospital to maintain standards of care and to remain competitive, they need to be able to invest in aging facilities, upgrade to advanced technologies, and expand or renovate to meet patient demands.

Table 2. Financial Indicators of St. Mary's Hospital and Waterbury Hospital (FY 2004 – 2006)

Financial Statistics	St. Mary's Hospital			Waterbury Hospital		
	2006	2005	2004	2006	2005	2004
Net Assets						
Hospital	($136,000)	$23,760,000	$26,430,000	$124,628,134	$126,535,925	$119,504,105
Health System	$1,424,000	$8,469,000	$16,197,000	$163,330,870	$166,079,218	$158,400,874
Financial Indicators						
Current ratio	0.8	1.96	1.78	2.03	2.15	1.93
Days of expenses in accounts payable	72	71	69	42	47	56
Days cash on hand	1	3	5	20	34	42
Days of revenue in accounts receivable	38	48	60	49	42	37

Source: *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2005, the hospitals' Audited Financial Statements &*data submitted by the hospitals in response to the investigation.*

Current Ratio: the Current Ratio is the most widely used measure of liquidity. The value of the Current Ratio measures the number of dollars held in current assets per dollar of current liabilities. From an evaluation perspective, high values for the Current Ratio imply a good ability to pay short term obligations and thus a low probability of technical insolvency. Nationally, Current Ratios fluctuate around 2.0.

System of Care

The infrastructure that provides access to outpatient primary care and behavioral health services overall appears to be fragmented and at capacity. The lack of access to primary health care is demonstrated by the high utilization of emergency departments and the high incidence of hospitalizations that could have been prevented if residents had adequate access to preventive community services (Attachment A). The clinics that each

hospital operates and the Federally Qualified Health Center in Waterbury also appear to be at capacity. Additionally, there is a serious concern with the ability for clinic patients to access specialty care since the majority of physicians do not accept many Medicaid patients.

In continued research regarding access to pediatric inpatient psychiatric services (Attachment E), it was recommended that Region 5 (Waterbury being part of) expand inpatient beds as well as develop a Psychiatric Residential Treatment Facility (PRTF). The lack of availability of different levels of care is creating long delays to transfer behavioral health patients to other providers and typically those referrals are out of the region.

Office of Health Care Access

Report of Investigative Proceedings

Subject Title:	**An Investigation to review utilization and capacity of acute care general hospital services provided in the "Waterbury Area"**
Docket Number:	**06-3070-VST**
Statutory Reference:	**Section 19a-633 of the Connecticut General Statutes**
Proceeding Date:	**December 19, 2006**
Presiding Officer:	**Cristine A. Vogel**
Date of OHCA Report:	**May 23, 2007**

Cristine A. Vogel
Commissioner
Office of Health Care Access

Findings of Fact

1. Saint Mary's Hospital ("SMH") is an acute care hospital located at 56 Franklin, Waterbury, Connecticut. SMH's total license capacity is 379 beds and bassinets.

2. Waterbury Hospital ("WH") is an acute care hospital located at 64 Robbins Street in Waterbury, Connecticut. WH's total licensed bed capacity is 393 beds and bassinets.

3. On May 25, 2006, the Office of Health Care Access (OHCA) pursuant to Connecticut General Statutes (C.G.S.) Section 19a-633 initiated an investigation to review utilization and capacity of acute care general hospital services provided in the "Waterbury Area." The general acute care hospitals located in the city of Waterbury are St. Mary's Hospital and The Waterbury Hospital.

4. **Table 1: Financial Performance of St. Mary's and Waterbury Hospitals (FYs 2004 – 2006)**

Financial Indicators	St. Mary's Hospital			Waterbury Hospital		
	FY 2004	FY 2005	FY 2006	FY 2004	FY 2005	FY 2006
Operating Loss/Gain[1]	$6,306,000	$(15,270,000)	$(6,393,000)	$(448,506)	$(2,431,845)	$(8,069,534)
Excess of Revenue over Expenses[2]	$11,480,000	$(6,581,000)	$744,000	$2,275,334	$(30,448)	$(5,303,186)
Operating Margin[3]	4.2%	(10.02)%	(3.7)%	(0.2)%	(1.2)%	(3.7)%
Total Margin[4]	7.68%	(4.3)%	0.44%	1.2%	(0.01)%	(2.4)%

Source: *Audited Financial Statements.*

[1] Loss or gain from reimbursement of patient services from government and non-government payers.

[2] Difference between revenue obtained from direct patient care and funds from other sources and expenses.

[3] Measures profitability and is the ratio of loss or gain per unit total operating revenue.

[4] Measures profitability and is the ratio of total operating and non-operating revenue loss or surplus to total operating revenue.

5. The investigation reviews current availability and utilization of, and demand for hospital services, system capacity and the challenges these two hospitals face in meeting demands from the community they serve. This involves an evaluation of:
   - the socio-economic make-up of the community that relies on services of the hospitals, implications on the hospitals' patient payer-mix and the effect of reimbursements on hospital operations and future plans;
   - current utilization and future demand for all hospital services including inpatient, emergency department, primary care clinics, outpatient psychiatric care and ancillary outpatient services in the area; and
   - challenges that exist in the market in general and their impact on the hospitals' operations.

6. OHCA determined that the following seven towns most frequently access health care services at "SMH" and "WH": Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown and Wolcott.

Table 2: Other Connecticut hospitals' percentage share of discharges originating from the seven selected towns, FYs 2003-2005

Acute Care Hospital	Middlebury %	Naugatuck %	Prospect %	Southbury %	Waterbury %	Watertown %	Wolcott %	% of Hospital Total
St. Mary's	**21.5**	**32.5**	**35.7**	**7.7**	**44.6**	**20.3**	**41.2**	**81.2**
Waterbury	**53.5**	**41.2**	**37.4**	**34.9**	**42.4**	**62.7**	**30.7**	**86.5**
Bridgeport	2.0	3.1	2.6	2.1	1.4	2.1	1.6	2.6
Danbury	5.7	2.1	0.5	38.9	1.1	1.9	0.5	6.8
John Dempsey	0.8	0.8	1.1	0.7	0.8	0.7	1.9	2.7
Griffin	1.1	5.9	1.4	1.7	0.5	0.4	0.3	5.2
St. Raphael's	2.8	2.5	4.8	1.8	1.5	1.4	2.6	2.1
Yale	6.8	5.9	8.7	6.2	3.6	4.7	4.2	2.8
Other*	5.7	6.0	7.8	6.0	4.3	5.8	17.1	0.6
Total (%)	**100**	**100**	**100**	**94**	**100**	**100**	**100**	
# of Discharges	**2,062**	**11,365**	**3,144**	**7,413**	**49,156**	**7,349**	**5,395**	

Source: *Office of Health Care Access Acute Care Discharge Database*
*Includes the other 23 hospitals, which individually did not discharge a significant share of patients from the seven towns.

7. According to Census 2000 data, approximately 208,861 residents live in the "Waterbury Area" as defined in Fact 6.

8. A significant portion of residents who rely on services provided by SMH and WH live in Waterbury, Naugatuck or Watertown and the socio-economics of this population is described as follows:

- young adults who may be full-time students, single, unemployed or have no permanent full-time jobs and therefore likely to be uninsured;
- a disproportionate share of residents who are over 75 years old live in the city of Waterbury who maybe inclined to suffer from chronic diseases that need management.
- minorities that have high hospitalization and uninsured rates;
- residents less likely to have a college degree or higher, to be skilled professionals or employed;
- a labor force that has a comparably higher tendency to work in service, production, transportation and material moving industries that are seasonal, temporary or part-time in nature;
- people who earn less than the statewide average per capita or household income;
- a population that has a high incidence of hospitalizations that could have been prevented if residents had adequate access to community health services; and
- a federally medically and primary care underserved population.

9. In November 2005, the Primary Care Office of the Connecticut Department of Public Health designated the city of Waterbury as a medically and a primary care underserved area under federal laws.

10.

Table 3: Licensed and Staffed Acute Care Beds in Waterbury Area by Service Line, FYs 2004 - 2006

Service Line	Licensed Beds	Staffed Beds FY 2006	Staffed Beds FY 2005	Staffed Beds FY 2004	% of Licensed Beds Staffed in FY 2006	% of All Staffed Beds in FY 2006	Share of Staffed Beds St. Mary's Hospital	Share of Staffed Beds Waterbury Hospital
Medical/Surgical	479	260	257	249	**54%**	**58%**	40%	60%
OB/GYN	64	62	63	63	**97%**	**14%**	50%	50%
Psychiatry	50	42	42	42	**84%**	**9%**	29%	71%
Critical Care	75	63	55	55	**84%**	**14%**	68%	32%
Pediatric	36	20	20	20	**56%**	**4%**	50%	50%
Total Beds	**704**	**447**	**437**	**429**	**63%**	**100%**	45%	55%
Total Bassinets	**68**	**68**	**68**	**68**	**100%**	**n/a**	47%	53%

11. Utilization for inpatient hospital services for the two hospitals combined:

Table 4: Waterbury Area Hospitals Acute Care Discharges by Service Line, FYs 2004 - 2006

Service Line	Discharges FY 2006	Discharges FY 2005	Discharges FY 2004	Discharges 3-yr Average	% Change 06/05	% Change 05/04	% Change 06/04
Medical	12,546	12,563	12,055	**12,388**	0	4	4
Surgical	7,548	7,527	7,352	**7,476**	0	2	3
Behavioral Health	1,538	1,721	1,650	**1,636**	-11	4	-7
Maternity/Pediatrics	5,930	5,942	6,118	**5,997**	0	-3	-3
Total	**27,562**	**27,753**	**27,175**	**27,497**	**-1**	**2**	**1**

12. The two hospitals combined have 73 emergency "beds" with the following breakdown by hospital:

Table 5: Waterbury Area Hospitals Emergency Department Beds, 2006

St. Mary's Hospital		Waterbury Hospital	
Description	Beds	Description	Beds
Treatment Room	24	Acute ER	21
Trauma room	2	Prompt Care	5
Behavioral Health	5	Behavioral Health	4
Urgi-care room	7	Surge (for high census & boarders)	5
Total	**38**	**Total**	**35**

13. SMH and WH report high utilization rates of emergency department (ED) visits when compared to the state and nation.

14. ED utilization broken down by hospital and combined:

Table 6: Waterbury Area Hospital Emergency Department Utilization, FYs 2004 - 2006

Hospital		FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	Treated & Discharged[1]	56,170	55,165	52,044	54,460
	Treated & Admitted[1]	8,286	8,177	7,581	8,015
	All ED Visits	64,456	63,342	59,625	62,474
Waterbury	Treated & Discharged	43,360	45,506	44,581	44,482
	Treated & Admitted	8,828	8,126	8,075	8,343
	All ED Visits	52,188	53,632	52,656	52,825
Waterbury Area Hospitals	**Treated & Discharged**	**99,530**	**100,671**	**96,625**	**98,942**
	Treated & Admitted	**17,114**	**16,303**	**15,656**	**16,358**
	All ED Visits	**116,644**	**116,974**	**112,281**	**115,300**
ED Utilization Per 1,000		558	560	538	552

15. Utilization of medical outpatient clinics vary by hospital as well as which type of services are offered. The two tables measure such activity; however, it was not determined that this data is comparable.

Table 7: St. Mary's Hospital Medical Clinic Visits by Service Line, FYs 2004 – 2006

	Visits				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Family Health	21,830	25,313	22,927	**23,357**	-14	10	-5
Children's Health	17,732	18,146	17,524	**17,801**	-2	4	1
Dental	7,460	6,715	6,342	**6,839**	11	6	15
Total	**47,022**	**50,174**	**46,793**	**47,996**	-6	7	0

Table 8: Waterbury Hospital Clinic Visits by Service Line, FYs 2004 - 2006

	Visits				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Chase Outpatient Center	10,712	8,581	10,806	**10,033**	25	-21	-1
HIV	1,138	997	451	**862**	14	121	60
Total	**11,850**	**9,578**	**11,257**	**10,895**	24	-15	5

16. Utilization of Outpatient Psychiatric Clinics vary by hospital as well as which type of services are offered. The table below measures such activity; however, it was not determined that this data is comparable.

Table 9: Waterbury Area Hospitals Outpatient Psychiatric Cases, Visits and Average Visits per Case, FYs 2004 - 2006

	Number of Cases				% Change		
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
St. Mary's	1,026	929	816	**924**	10	14	26
Waterbury	10,978	11,428	11,854	**11,420**	-4	-4	-7
Waterbury Area	**12,004**	**12,357**	**12,670**	**12,344**	-3	-2	-5
	Number of Visits				% Change		
Hospital	FY2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
St. Mary's	6,712	5,898	3,731	**5,447**	14	58	80
Waterbury	26,100	28,601	29,566	**28,089**	-9	-3	-12
Waterbury Area	**32,812**	**34,499**	**33,297**	**33,536**	-5	4	-1
	Average Visits/Case						
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average			
St. Mary's	7	6	5	**6**			
Waterbury	2	3	2	**2**			
Waterbury Area	**3**	**3**	**3**	**3**			

17. Utilization of "other" outpatient services (one-day surgery, radiology, laboratory, GI, etc.) is presented below. Data varies between each hospital and may not be consistent or necessarily comparable.

Table 10: Waterbury Area Hospitals Other Outpatient Utilization, FYs 2004 - 2006

	Visits				% Change		
Hospital	FY2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
St. Mary's	135,516	131,538	141,478	136,177	3	-7	-4
Waterbury	110,122	111,971	119,728	113,940	-2	-6	-8
Waterbury Area	**245,638**	**243,509**	**261,206**	**250,118**	1	-7	-6
Utilization Per 1,000	1,176	1,166	1,251	1,198			

18.

Table 11: Waterbury Area Hospitals Primary Payer Payment to Cost, FYs 2003 - 2005

	St. Mary's Hospital			Waterbury Hospital			Connecticut		
	FY03	FY04	FY05	FY03	FY04	FY05	FY03	FY04	FY05
Ratio of cost to charges	0.44	0.44	0.47	0.42	0.36	0.34	0.49	0.46	0.44
Medicare payment to cost	1.03	1.12	1.03	0.89	0.95	0.96	0.97	0.97	0.97
Medicaid payment to cost	0.85	0.80	0.47	0.68	0.82	0.79	0.73	0.73	0.72
Private payment to cost	0.95	1.08	0.96	1.02	1.07	1.06	1.14	1.18	1.20

Source: *Office of Health Care Access Hospital Financial Stability Reports for multiple years*

19.

Table 12: Waterbury Area Hospitals Payer Mix by Department, FYs 2004 - 2006

Services	Primary Payer	St. Mary's (%)			Waterbury (%)			Waterbury Area Hospitals (%)		
		FY06	FY05	FY04	FY06	FY05	FY04	FY06	FY05	
Inpatient Discharges	Medicare	42	43	43	44	43	43	**43**	**43**	**43**
	Medicaid	25	23	23	21	20	20	**23**	**22**	**21**
	Commercial	31	32	32	33	34	34	**32**	**33**	**33**
	Worker's Compensation	1	1	1	1	1	1	**1**	**1**	**1**
	Self-pay/uninsured	1	1	1	1	2	1	**1**	**1**	**1**
		100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Emergency Department Treated and Discharged Visits	Medicare	14	15	15	17	18	18	**15**	**16**	**16**
	Medicaid	49	46	43	34	33	32	**42**	**40**	**38**
	Commercial	26	27	29	36	37	37	**30**	**32**	**33**
	Worker's Compensation	2	2	3	3	3	3	**2**	**3**	**3**
	Self-pay/uninsured	9	9	10	11	10	10	**10**	**10**	**10**
		100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Outpatient Behavioral Health Visits	Medicare	9	13	9	46	47	45	**43**	**44**	**42**
	Medicaid	55	58	54	37	35	38	**38**	**37**	**39**
	Commercial	36	28	36	15	16	16	**17**	**17**	**17**
	Worker's Compensation	0	0	0	0	0	0	**0**	**0**	**0**
	Self-pay/uninsured	1	1	0	2	2	2	**2**	**2%**	**2**
		100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
All Other Outpatient Visits	Medicare	32	33	32	30	31	32	**31**	**32**	**32**
	Medicaid	17	17	16	18	18	18	**18**	**18**	**17**
	Commercial	47	47	46	45	45	45	**46**	**46**	**45**
	Worker's Compensation	1	1	3	1	1	1	**1**	**1**	**2**
	Self-pay/uninsured	2	2	3	5	5	4	**4**	**3**	**4**
		100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Total	**Medicare**	**28**	**28**	**28**	**32**	**33**	**33**	**30**	**31**	**31**
	Medicaid	**26**	**26**	**24**	**20**	**19**	**19**	**23**	**23**	**22**
	Commercial	**41**	**41**	**41**	**42**	**42**	**42**	**41**	**42**	**41**
	Worker's Compensation	**2**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	**2**
	Self-pay/uninsured	**4**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	**4**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

20.

Table 13: Waterbury Area Hospitals Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 - 2006

Service Line	Gain or Loss Per Discharge/Case ($)[1]				% Change		
	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Medical	(127)	62	322	**82**	-306	-81	353
Surgical	(1,871)	(1,112)	(850)	**(1,282)**	68	31	55
Behavioral Health	(2,834)	(1,805)	(1,472)	**(2,015)**	57	23	48
Maternity/Pediatrics	(794)	(765)	(927)	**(830)**	4	-18	-17
Total	**(899)**	**(549)**	**(386)**	**(612)**	64	42	57

[1] The combined per case gain/loss is sum of total revenue for the two hospitals minus the sum of their total costs divided by sum of discharges from both hospitals.

Table 14: Waterbury Area Hospital Emergency Department Gain or Loss Per Treated & Discharged Visit, FYs 2004 - 2006

Hospital	Gain or Loss Per Discharge/Visit ($)			
	FY 2006	FY 2005	FY 2004	3 Yr. Average
St. Mary's	(22)	(15)	24	**(5)**
Waterbury[2]	(36)	(29)	(30)	**(32)**
Waterbury Area Hospitals	**(28)**	**(21)**	**(1)**	**(17)**

[1] For each cell, the combined per case gain/loss is sum of net revenues for the two hospitals minus the sum of total costs for the two divided by sum of discharges from both hospitals.

21. SMH and WH jointly contracted with The Chartis Group, LLC to conduct an assessment and financial review to present options of integration of the two hospitals. The table below summarizes the costs associated with the different Levels:

Table 15: Projected Costs Associated with Levels of Integration.

	Level One ("Millions")	**Level Two** ("Millions")	**Level Three** ("Millions"
A. Affiliation Costs	$ 12.0	$ 17.0	$ 25.0
B. Technical Costs	$ 12.2	$ 12.2	$ 12.2
C. Facilities Costs	$ 1.0	$ 3.9	$ 62.2
	$ 25.2	**$ 33.1**	**$ 99.4**

Level 1: Administrative and Operational Support Integration only
Level 2: Limited Clinical Integration and Level 1
Level 3: Full Administrative and Clinical Integration

22. According to The Chartis Group presentation, all levels of integration show a positive financial gain 5 years out. There would be a significant spend down or depletion of WH cash reserves to facilitate the affiliation. Therefore, WH would be at risk of violating some of its bond covenants and possibly alter its credit profile and its future access to capital.

23. According to The Chartis Group presentation, SMH and WH have internal issues that would need to be addressed, such as: Catholic and Secular organizations, WH has a unionized workforce, SMH liabilities, and a general cultural divide between the two organizations.

24. StayWell Health Center is a federally-qualified health center located in Waterbury, Connecticut, and provides primary care, dental and behavioral health services.

25. In fiscal year 2006, StayWell provided 55,687 visits, a rate of growth of 275% When compared to fiscal year 2000.

26. According to StayWell's letter to the agency, the organization struggles with staffing. "With the shortage in qualified nurses, we are frequently competing for staff. We have seen this to be the case for physicians also. Hiring culturally competent staff is always a struggle and then unfortunately added to the existing community shortages. Ultimately, staffing shortages impact access to care when special outreach services or walk-in hours need to be suspended due to inadequate staff to assign."

27. According to StayWell's letter, "We have difficulty getting access to Specialists who are not interested in seeing our patients. The low reimbursement rates for Title 18 and Title 19 for non-community health care providers has a trickle down effect on our patients."

28. According to a recent telephone conversation held between Commissioner Vogel and Donald Thompson of StayWell, in general StayWell Health Center's growth is limited by the space it occupies.

29. Connecticut has experienced 6 mergers; one closure of a small rural community hospital; one acquisition and conversion of a small non-profit to the state's only for-profit hospital; and the construction of a new children's hospital and a 94-bed community hospital (both results of mergers).

30. After reviewing the closures and mergers, it was apparent that each circumstance was different depending upon the financial strengths and weakness of the hospitals involved. In all of the mergers (in the cities of Bridgeport, Hartford and Meriden) one hospital was financially capable of absorbing the debt of the less viable; and in no circumstances was the State of Connecticut financially responsible for merger/closure activity.

31. The "Report of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Group" examined the previous report regarding the current situation of inpatient services available for children & adolescents and offered recommendations to address the need and capacity for such services.

32. Region 5 has six acute care hospitals (Charlotte Hungerford, New Milford, Sharon, Danbury, St. Mary's and Waterbury) but has only five inpatient beds to serve the area and no free-standing psychiatric hospital.

33. The five inpatient beds for adolescent behavioral health services are located at Waterbury Hospital.

34. The Implementation Group recommends an additional 20 to 30 inpatient psychiatric beds are required in Region 5.

35. The data indicate that the majority of discharges are from the areas of Waterbury (27%), Danbury (11%), and Torrington (8%).

36. The Implementation Group recommends to establish 15 – 25 Psychiatric Residential Treatment Facility beds in Region 5.

IV. Discussion and Conclusion

The main purpose and intent of the processes undertaken by OHCA under the Investigative Proceeding of Docket Number 06-30760-INV was to gather and analyze pertinent data and facts regarding the utilization, capacity and demand, and the challenges to meet these demands in the Waterbury area. The financial condition of both SMH and WH were critical to this assessment. The following is a discussion of the results of the analysis and OHCA's conclusions. All conclusions are independent of Certificate of Need decisions and any review and issuance of CHEFA bonds. Any coordination of services must proceed in full conformance with the antitrust laws.

Throughout this investigation it became evident, either through data or by comments of those involved, that having two hospitals within the city of Waterbury is a root cause for the financial hardship experienced by both hospitals. As a community served by one hospital and one outpatient services system the financial stability of the remaining hospital would return through:

- Improved commercial payer rates
- Improved payer mix of patients
- Reduced expenses related to marketing/advertising/recruitment
- Reduced expenses in duplicative services
- Gain a competitive advantage over hospitals located in the secondary markets

Ideally this one inpatient/outpatient system would further develop an integrated and comprehensive primary care and behavioral health care system with the overriding goal to improve the health status of the community and reduce the number of ED visits and unnecessary hospitalizations.

There has been much discussion regarding the state's Medicaid reimbursement being a lead factor in the financial deterioration since a large portion of the patients are covered by Medicaid. A brief review of the percentage of Medicaid inpatient discharges from other hospitals located in similar markets shows that St. Mary's is the third highest Medicaid inpatient provider and Waterbury Hospital is within the state's average. As Table 1 demonstrates, it is difficult to directly correlate the percentage of inpatients by payer source to profit margins. Payer mix is a strong variable in a hospital's financial condition, but other operational factors play a significant role as well. The patient mix for ED discharges for St. Mary's is 49% and for Waterbury Hospital is 34% (comparable data for other hospitals is not available).

Table 1. FY06 Inpatient Discharge Patient Mix by Payer Source; Total Discharges, Total Profit Margin and Operating Profit Margin

Hospital	Medicare	Medicaid	Private	Uninsured	Total Discharges	Total Margin	Operating Margin
Bridgeport	34%	25%	38%	2%	19,574	4.1%	1.4%
St. Vincent's	46%	14%	35%	5%	19,672	9.4%	3.8%
Hartford	38%	18%	41%	3%	39,323	2.4%	0.0%
St. Francis	41%	20%	37%	2%	31,647	1.0%	-0.1%
Yale-New Haven	28%	25%	44%	2%	50,354	3.9%	2.1%
St. Raphael	53%	13%	33%	1%	25,354	-2.1%	-2.6%
Stamford	35%	16%	46%	4%	17,003	6.1%	5.1%
New Britain	41%	21%	35%	3%	18,585	4.3%	3.3%
St. Mary's	42%	23%	33%	2%	12,718	0.4%	-3.7%
Waterbury	45%	18%	35%	2%	15,000	-2.4%	-3.6%
Statewide	40%	17%	39%	3%	423,051	2.5%	0.6%

Source: OHCA Discharge Database and FY06 Financial Audited Statements (profit margins are hospital only)

Although any improvement to any of the payer reimbursement will benefit the two hospitals – it alone will not address the fundamental issues of fragmentation, duplication, competition and the ability to improve access to capital.

Recently the hospitals have engaged in discussions on the matter of integrating or consolidating services. They jointly contracted a consultant and shared some of the findings as part of this investigation. The consultant's analysis explored the potential options and the costs associated with each option. Realizing that "Level 1 Integration of Administrative and Operational Support Only" would be the most achievable first step, it offers limited long-term sustainability, costs an estimated $25 million, would continue the two-hospital campus with different organizational cultures, and it would have difficulties differentiating itself in the marketplace. The other levels of integration begin to consolidate services and structurally become one hospital with two locations. The costs rise significantly with these options from approximately $33 to $100 million; however, they begin to realize the benefits of a merged entity.

These figures are only estimates; however, they provide insight to the real costs of integration. In other mergers that have occurred in Connecticut (Attachment D), typically one of the hospitals involved was financially capable of absorbing the debt of the less viable hospital and the associated costs of the merger. Of concern is the inability of the hospitals to fund the potential integration.

This situation differs from other mergers in the state because both hospitals are in financial distress and utilization of services remains active. If a merger were to occur, Waterbury Hospital would be responsible to absorb any liabilities and debt of St. Mary's Hospital and that will further weaken the stability of Waterbury Hospital. The hospitals

are aware of some services that can be consolidated (termination of services from one hospital and transferring the patients to the remaining program may require Certificate of Need approval). Such services may include neurology, certain surgical procedures, orthopedics, cardiology, maternity, neonatology, the on-call system for the coverage of two EDs, trauma services, and ancillary services (i.e., laundry, laboratory, pathology, etc.). A slow and deliberate closure of St. Mary's Hospital may also be a viable option.

In conclusion, St, Mary's Hospital's financial measures indicate that the hospital is insolvent. The annual infusion of state funding, although enabling continued access for patients, does not address nor resolve the fundamental system issues that are creating the on-going losses. St. Mary's Hospital should be responsible for providing adequately for its employees during this transition and fully fund the pension obligation. In the event of a closure or merger, the remaining hospital will be able to absorb some of the volume; however, it will need to reconfigure and possibly expand the inpatient services. Removing the competition and duplication in the profitable outpatient market is critical to be able to flow funds back into the remaining hospital system to ensure sustainability.

The infrastructure for primary care and behavioral health care services needs to be re-designed and a comprehensive and integrated system developed. Ideally, a system of care that involves the hospital, the community health centers, community providers and school-based clinics will serve the population well. Additionally, the community may benefit from a workforce development plan as the system begins to reshape the health care delivery system.

St. Mary's Hospital, the Waterbury Hospital and the state agencies were actively involved in this investigatory process. Both hospitals are committed to providing high quality patient care and continue discussions regarding how to best sustain access and return financial stability to the delivery system of the Waterbury community.

Attachment A

State of Connecticut

REPORT OF SOCIO-ECONOMICS AND HEALTH CARE SERVICES UTILIZATION OF THE WATERBURY AREA

Docket Number 06-30760-VST

Cristine A. Vogel
Commissioner
Office of Health Care Access

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APPENDICES

1.0 Introduction

On May 25, 2006, the Office of Health Care Access (OHCA) pursuant to Connecticut General Statutes (C.G.S.) Section 19a-633 (Appendix A), initiated an investigation to review utilization and capacity of acute care general hospital services provided in the "Waterbury Area." The general acute care hospitals located in the city of Waterbury are St. Mary's Hospital and The Waterbury Hospital.

The investigation stemmed from concerns about the long-term viability of either or both hospitals, and their ability to provide and maintain needed health care services in the communities they serve vis-à-vis their financial performance in the last two fiscal years (FY) (Table 1). In addition to providing acute inpatient care, the hospitals serve as a safety net for residents of the area who do not have access to or cannot afford primary care. Based on the hospitals audited financial statements, both hospitals are operating at a loss from direct patient care; the hospitals' expenses exceed revenue from direct patient care and other operating revenue; inadequate funds obtained from philanthropic or non-philanthropic sources not directly related to patient care; as well as other issues discussed in this report.

Table 1: Financial Performance of St. Mary's and Waterbury Hospitals (FYs 2004 – 2006)

Financial Indicators	St. Mary's Hospital			Waterbury Hospital		
	FY 2004	FY 2005	FY 2006	FY 2004	FY 2005	FY 2006
Operating Loss/Gain[1]	$6,306,000	$(15,270,000)	$(9,694,000)	$(448,506)	$(2,431,845)	$(5,262,405)
Excess of Revenue over Expenses[2]	$11,480,000	$(6,581,000)	$(6,197,000)	$2,275,334	$(30,448)	$(2,479,026)
Operating Margin[3]	4.2%	(10.02)%	(4.7)%	(0.2)%	(1.2)%	(2.2)%
Total Margin[4]	7.68%	(4.3)%	(3.0)%	1.2%	(0.01)%	(1.1)%

Source: *Audited Financial Statements.*
[1] Loss or gain from reimbursement of patient services from government and non-government payers.
[2] Difference between revenue obtained from direct patient care and funds from other sources and expenses.
[3] Measures profitability and is the ratio of loss or gain per unit total operating revenue.
[4] Measures profitability and is the ratio of total operating and non-operating revenue loss or surplus to total operating revenue.

The investigation reviews current availability and utilization of, and demand for hospital services, system capacity and the challenges these two hospitals face in meeting demands from the community they serve. This involves an evaluation of:

- the socio-economic make-up of the community that relies on services of the hospitals, implications on the hospitals' patient payer-mix and the effect of reimbursements on hospital operations and future plans;
- current utilization and future demand for all hospital services including inpatient, emergency department, primary care clinics, outpatient psychiatric care and ancillary outpatient services in the area; and
- challenges that exist in the market in general and their impact on the hospitals' operations.

On the basis of this investigative proceeding, OHCA will make recommendations for ensuring continued availability and access to health care for the area.

2.0 Determining the towns of the "Waterbury Area"

The towns a hospital provides services to make up its primary and secondary service areas. Primary service area towns are either a significant portion of the hospital's patient base or most residents from the towns access services at the hospital; and the secondary service area consists of all other towns whose residents access the hospital's services at a steady but lower rate. This investigation determines which towns will be most adversely impacted if one of the two hospitals or both are unable to provide services. Therefore, to determine which towns rely significantly on health care services that the two hospitals provide, OHCA first included towns that comprise the top 70% of each of the two hospitals' acute care inpatient discharges. Based on this definition, OHCA identified Waterbury and Naugatuck for St. Mary's Hospital and these same towns and an additional two, Watertown and Southbury, for the Waterbury Hospital (Table 2).

Table 2: Towns of Origin for St. Mary's Hospital and Waterbury Hospital Top Seventy Percent Discharges (FY 2003 – 2005)

	St. Mary's Hospital			Waterbury Hospital		
Patient Town	# Discharges	% of Hospital Total	Cum % Total	# Discharges	% of Hospital Total	Cum % Total
Waterbury	21,903	60.2	60.2	20,818	46.1	46.1
Naugatuck	3,693	10.2	70.4	4,685	10.4	56.5
Watertown	n/a	n/a	n/a	4,610	10.2	66.7
Southbury	n/a	n/a	n/a	2,588	5.7	72.4

Source: *Office of Health Care Access Acute Care Discharge Database*

Other towns were included if the combined share of patients originating from that town for the two hospitals exceeded 70%, demonstrating a significant reliance of the town on the health care system in Waterbury. Middlebury, Prospect and Wolcott became part of the group because the two hospitals account for about three-quarters of discharges originating from each town, bringing the number of towns in the "Waterbury Area" to seven, namely Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown and Wolcott (Table 3).

Table 3: Percent of Patients from Selected Towns Discharged from St. Mary's Hospital and Waterbury Hospital (FY 2003-2005)

Patient Town	St. Mary's Hospital % Share	Waterbury Hospital % Share	Combined % Share
Middlebury	21.5%	53.5%	75.0%
Naugatuck	32.5%	41.2%	73.7%
Prospect	35.7%	37.4%	73.1%
Southbury	7.7%	34.9%	42.6%
Waterbury	44.6%	42.4%	87.0%
Watertown	20.3%	62.7%	83.0%
Wolcott	41.2%	30.7%	71.9%

Source: *Office of Health Care Access Acute Care Discharge Database*

Patients residing in the seven towns included make up over 80% of each hospital's discharges. Although residents of those towns migrate to nearby hospitals to receive care most utilize the Waterbury hospitals more than any other single hospital (Table 4). Patient migration to access care in other areas depends on factors such as patient preference, patient ability to travel and physician referral patterns. Out-migration from local areas also occurs because certain treatment modalities or physician specialists are available outside the Waterbury area.

Table 4: Other Connecticut hospitals' percentage share of discharges originating from the seven selected towns, FYs 2003-2005

Acute Care Hospital	Middlebury %	Naugatuck %	Prospect %	Southbury %	Waterbury %	Watertown %	Wolcott %	% of Hospital Total
St. Mary's	**21.5**	**32.5**	**35.7**	**7.7**	**44.6**	**20.3**	**41.2**	**81.2**
Waterbury	**53.5**	**41.2**	**37.4**	**34.9**	**42.4**	**62.7**	**30.7**	**86.5**
Bridgeport	2.0	3.1	2.6	2.1	1.4	2.1	1.6	2.6
Danbury	5.7	2.1	0.5	38.9	1.1	1.9	0.5	6.8
John Dempsey	0.8	0.8	1.1	0.7	0.8	0.7	1.9	2.7
Griffin	1.1	5.9	1.4	1.7	0.5	0.4	0.3	5.2
St. Raphael's	2.8	2.5	4.8	1.8	1.5	1.4	2.6	2.1
Yale	6.8	5.9	8.7	6.2	3.6	4.7	4.2	2.8
Other*	5.7	6.0	7.8	6.0	4.3	5.8	17.1	0.6
Total (%)	**100**	**100**	**100**	**94**	**100**	**100**	**100**	
# of Discharges	**2,062**	**11,365**	**3,144**	**7,413**	**49,156**	**7,349**	**5,395**	

Source: *Office of Health Care Access Acute Care Discharge Database*
*Includes the other 23 hospitals, which individually did not discharge a significant share of patients from the seven towns.

3.0 Socio-economic profile of the Waterbury Area

Socio-economic status, that is age, gender, race or ethnicity, educational attainment, employment status and income and physician availability, are well-documented joint indicators of health status, need for health care services, timeliness of heath care treatment, and ability to pay for health care services. Therefore, this section examines the social and economic characteristics of the Waterbury area population for insight into the type of services needed, the ability to pay for and the ease of access to health care services. The section also provides information on the inherent patient payer mix experienced by both hospitals.

A. Population and age distribution

According to Census 2000, there are approximately 208,861 residents in the Waterbury area, which is 6% of the state's population. About 51.4% of the area's residents live in Waterbury, 14.8% in Naugatuck and 10.4% in Watertown and a combined 23.4% in Southbury, Wolcott, Prospect and Middlebury (Table 5).

Table 5: Population and Age Distribution of the Waterbury Area

Patient Town	0-19	20-44	45-64	65-74	75+	2000 Population	% of Total
Middlebury	26.0%	28.0%	29.3%	8.0%	8.4%	6,451	3.1%
Naugatuck	29.1%	38.1%	21.0%	5.4%	6.3%	30,989	14.8%
Prospect	26.9%	33.7%	26.0%	6.8%	6.3%	8,707	4.2%
Southbury	24.0%	24.8%	25.1%	9.9%	16.2%	18,567	8.9%
Waterbury	28.9%	36.3%	19.7%	6.7%	8.2%	107,271	51.4%
Watertown	26.7%	34.2%	24.8%	7.0%	7.0%	21,661	10.4%
Wolcott	27.9%	34.9%	23.9%	6.9%	6.1%	15,215	7.3%
Total	**28.1%**	**34.9%**	**21.8%**	**6.9%**	**8.3%**	**208,861**	**100.0%**
Connecticut	**27.1%**	**35.8%**	**23.1%**	**6.7%**	**7.0%**	**3,405,565**	

Source: *U.S. Census Bureau Census 2000*

Some age characteristics of this area are:

- Children under 19 years old are overrepresented in Naugatuck although there is no significant difference between children's share of the area and state population.
- Naugatuck and Waterbury residents, representing almost two-thirds of the area, have a relatively larger share of 20 to 44-year olds. According to OHCA research, 19 to 29 year-olds are four times as likely to be uninsured because they may be full-time students, single, unemployed or have no permanent full-time jobs. This means they are less likely to have health insurance coverage through an employer, are too old to receive coverage from a parent who has coverage through an employer and are ineligible for Medicaid.[1]
- Fewer adults in the 45 to 64 age range, a group that is likely to be employed and insured, compared to the state.[2] In Waterbury, there are only 19.7% in this age range compared to 23.1% in the state.
- Waterbury, representing about one-half of the area, has relatively more residents over 75 years than the state, 8.2% versus 7.0%. This age group has the highest potential to suffer from chronic diseases, experiences greater disease acuity and tend to have higher hospitalization rates than the general population and therefore costs more to treat.[3] Older residents are also less mobile and tend to access care in the local area.

B. Gender mix

The gender mix provides information on the types and volume of services the area needs. The gender mix of the area is similar to that of the state with slightly more women than men, although Southbury, Waterbury, Watertown have relatively more women than average (Table 6). Generally younger women tend to require hospitalization 2.5 times as more frequently as their male counterparts due to pregnancies and childbirth, but this disparity narrows, as women get older. In fact, even at age 65 and over when hospitalizations are 2.6 times the rate for the general population, men tend to require acute care at a higher rate than women of the same age cohort.[4]

Table 6: Gender Mix of Waterbury Area

Patient Town	Males	Females	Males %	Females %
Middlebury	3,127	3,324	48.5	51.5
Naugatuck	15,069	15,920	48.6	51.4
Prospect	4,255	4,452	48.9	51.1
Southbury	8,633	9,934	46.5	53.5
Waterbury	50,781	56,490	47.3	52.7
Watertown	10,379	11,282	47.9	52.1
Wolcott	7,411	7,804	48.7	51.3
Total	**99,655**	**109,206**	**47.7**	**52.3**
Connecticut	**1,649,319**	**1,756,246**	**48.4**	**51.6**

Source: *U.S. Census Bureau Census 2000*

C. Racial composition

Research shows that minorities[5], especially Blacks and Hispanics or Latinos, are hospitalized at rates disproportionate to their share of the population than Whites.[6] Hispanics or Latinos are also 3.5 times as likely to be uninsured as all races in the state.[7] Six of the towns in the area are predominantly White compared to the state in general, but because Waterbury, which is about one-half of the area, has a significantly large minority population, mostly Hispanics and Blacks, the area has almost 1.5 times more minorities than the state (Table 7).

Table 7: Racial and Ethnic Distribution of Residents in the Waterbury Area

			Minorities			
Patient Town	Total Population	% White Alone	% Hispanic/Latino (of any race)	% Black Alone	% Asian Alone	% Other races excluding Hispanics/Latinos
Middlebury	6,451	96.2	1.2	0.4	1.3	0.9
Naugatuck	30,989	88.9	4.5	2.8	1.7	2.1
Prospect	8,707	95.0	1.9	1.4	0.7	1
Southbury	18,567	96.1	1.6	0.5	1.2	0.7
Waterbury	107,271	58.2	21.8	16.3	1.5	2.3
Watertown	21,661	95.2	1.9	0.7	1.3	0.8
Wolcott	15,215	95.2	1.8	1.2	0.7	1
Total	**208,861**	**75.4**	**12.4**	**9.1**	**1.4**	**1.8**
Connecticut	**3,405,565**	**77.5**	**9.4**	**9.1**	**2.4**	**1.6**

Source: *U.S. Census Bureau Census 2000*

D. Educational attainment

In general, higher educational attainment enhances employment prospects and the chances of gaining employment with an employer who provides health insurance coverage for eligible employees, especially for skilled labor. In the Waterbury area, fewer residents 25 years and over graduated from high school or have a college degree than the state in general, 78.9% compared to 84.0%. The residents are also 1.5 times less likely to have a bachelor's degree or higher (Table 8).

Table 8: Educational Attainment of the Waterbury Area 25 Years and Over Population

Patient Town	Population 25 Years and Over	% High School Graduate or Higher	% Bachelor's Degree or Higher
Middlebury	4,662	91.9	41.5
Naugatuck	20,451	83.0	19.0
Prospect	6,015	87.1	22.8
Southbury	13,727	89.2	31.4
Waterbury	69,791	71.7	13.9
Watertown	14,922	83.8	25.0
Wolcott	10,350	87.8	19.3
Total	139,918	78.9	20.3
Connecticut	2,295,617	84.0	31.4

Source: *U.S. Census Bureau Census 2000*

E. Employment status and occupation

There are also fewer residents of the Waterbury area in the civilian labor force relative to the state, 49.3% versus 51.6%. The area total is lower mainly because only 46.4% of the city of Waterbury's residents are in the labor force (Table 9). Regardless, the city also has the highest unemployment rate, over 1.5 times the rate for the state, 8.6% versus 5.3%. This means potentially more people in the area are unable to afford needed health care services.

Table 9: Employment Status of Waterbury Area 16 Years and Over Civilian Labor Force

		Population 16 Years and Over		
Patient Town	Population	% of Civilian Labor Force	% of Civilian Labor Force Employed	% of Civilian Labor Force Unemployed
Middlebury	6,451	52.9	97.5	2.5
Naugatuck	30,989	53.1	94.7	5.3
Prospect	8,707	55.1	97.9	2.1
Southbury	18,567	44.6	96.9	3.1
Waterbury	107,271	46.4	91.4	8.6
Watertown	21,661	54.9	95.4	4.6
Wolcott	15,215	54.6	95.7	4.3
Total	**208,861**	**49.3**	**93.7**	**6.3**
Connecticut	**3,405,565**	**51.6**	**94.7**	**5.6**

Source: *U.S. Census Bureau Census 2000*

Only 56.1% residents of the area are in "management and professional' and "sales and office" occupations compared to 65.6% of the state as a whole (Table 10). These occupations tend to be higher paying and permanent full-time positions, which increase the likelihood of being able to afford and/or qualify for employer-sponsored health insurance (ESI) coverage. Instead, area residents, especially those residing in Waterbury, have a comparatively higher tendency to be in "service" and "production, transportation and material moving," occupations that are seasonal, temporary or part-time in nature which lessen residents' ability to qualify for or to afford ESI when offered.

Table 10: Occupations of Waterbury Area 16 Years and Over Civilian Labor Force

Patient Town	% in Management, Professional, & Related Occupations	% in Service	% in Sales & Office	% in Farming, Fishing, Forestry	% in Construction, Extraction, & Maintenance	% in Production, Transportation, Material Moving
Middlebury	52.1	13.3	20.6	0.0	6.0	8.0
Naugatuck	30.3	15.6	25.1	0.1	10.1	19.0
Prospect	37.1	11.3	28.0	0.1	8.6	14.7
Southbury	47.6	11.6	24.2	0.3	8.3	8.0
Waterbury	25.1	20.1	24.6	0.1	8.8	21.4
Watertown	35.5	16.4	23.6	0.1	8.5	15.9
Wolcott	33.9	14.6	28.3	0.1	9.6	13.5
Total	**31.2**	**17.1**	**24.9**	**0.1**	**8.9**	**17.8**
Connecticut	**39.1**	**14.3**	**26.5**	**0.2**	**8.0**	**12.0**

Source: *U.S. Census Bureau Census 2000*

F. Per capita and average household incomes

Higher individual or family incomes are linked to greater ability and willingness to spend on needed health care services. Per capita and average household incomes are the proxies for measuring what an individual or a family can afford. For most towns in the Waterbury area, both amounts are below the state average, resulting in a low average for the area in general, $28,505 versus the state's $31,816 and $76,939 compared to $82,601 (Table 11).

Table 11: Per Capita and Average Household Income for Waterbury Area Residents

Patient Town	Per Capita Income ($)	Median Household Income ($)	Average Household Income ($)
Middlebury	39,129	68,090	105,684
Naugatuck	25,477	56,677	67,314
Prospect	26,881	68,770	79,946
Southbury	34,318	64,437	85,269
Waterbury	21,238	41,258	51,888
Watertown	24,276	57,832	66,766
Wolcott	28,214	71,144	81,709
Total	**28,505**	**64,437**	**76,939**
Connecticut	**31,816**	**59,697**	**82,601**

Source: *CT Department of Economic & Community Development 2000 Data from Claritas*

G. Estimated rate and number of uninsured

The "estimated" uninsured rate for Waterbury area residents based on the OHCA 2006 Household Survey is over 1.5 times the rate for the state, that is, 9.8% compared to 6.4% (Table 12).

Table 12: Estimated rate and number of uninsured in Waterbury Area, 2006

Uninsured Rate (%)			Estimated Number Uninsured		
Lower	Estimate	Upper	Lower	Estimate	Upper
5.9	**9.8**	13.7	12,688	**21,034**	28,380

Source: *CT Office of Health Care Access 2006 Household Survey and U.S. Census Bureau 2005 Population Estimates*

[1] The estimated uninsured rate will fall within the given lower and upper boundaries 95% of the time if the survey were repeated 100 times. The estimated rate of uninsured for the state is 6.4%.

H. Rate of preventable hospitalization

Preventable hospitalizations (PH) are acute care admissions that would not have occurred, if patients had received "timely and effective primary care and medical management."[8] Such conditions include asthma, angina, bacterial pneumonia, chronic obstructive pulmonary disease, congestive heart failure, dehydration, diabetes, hypertension, low birth weight, lower extremity amputation, pediatric gastroenteritis, perforated appendix and urinary infection. Based on a methodology developed by the federal Agency for Healthcare Research and Quality (AHRQ), the Waterbury area has a relatively higher incidence of PH than the state for children and adults, 1.9 versus 1.2 and 1.5 versus 1.2 per 1,000 of the respective population (Table 13). For both age groups, the city of Waterbury had the highest incidence of PH, which was also twice the state rate.

Table 13: Ambulatory Care Sensitive Condition* Discharges per 1,000 population, FYs 2000 – 2004

Patient Town	Children (0-17)	Adults (18+)
Middlebury	2	1.3
Naugatuck	1.9	1.8
Prospect	1.7	1.5
Southbury	0.7	1.3
Waterbury	4.2	2.5
Watertown	2.3	1.4
Wolcott	1.8	1.5
Median for Area	**1.9**	**1.5**
Median for Connecticut	**1.2**	**1.2**

Source: *Office of Health Care Access Acute Care Discharge Database*

*Conditions include asthma, angina, bacterial pneumonia, chronic obstructive pulmonary disease, congestive heart failure, dehydration, diabetes, hypertension, low birth weight, lower extremity amputation, pediatric gastroenteritis, perforated appendix and urinary infection.

I. Primary care physicians per 1,000 of area population

There is a recognized link between receiving primary care and improved health status. Payers of health care services broadly define primary care physicians (PCP) to include family or general practice physicians, pediatricians, internists, nurse practitioners, physician assistants and naturopathic physicians. These PCPs, including being trained to treat a wide range of diseases, maintain comprehensive records of patients, refer patients to specialists, coordinate care provided to patients by specialists and facilities, and manage patients' chronic health conditions. Ideally, a PCP should be a patient's first contact in a health care system. But generally, these PCPs are not distributed evenly between communities in the state and across the nation. In November 2005, the Primary Care Office of Connecticut Department of Public Health (DPH) designated the city of Waterbury as a medically and a primary care underserved area under federal law as an initial step to improving access to primary health care in the area.[9]

4.0 Hospital services utilization, payer reimbursement and mix

This section discusses the utilization of hospital services in the Waterbury area and identifies the payers of those services. This includes a discussion of acute care inpatient bed capacity, availability and utilization; emergency department use; outpatient psychiatric and other outpatient services utilization; and payer mix in these areas of operation. Unless otherwise stated, the two hospitals provided all the data for this section in response to OHCA's preliminary questions for the investigation; FY 2006 data are annualized.

A. Inpatient bed capacity, occupancy and availability

The "size" or "capacity" of inpatient services is the average number of inpatient beds a hospital staffs. Occupancy is the average number of staffed beds in use by midnight census throughout the year. The Department of Public Health (DPH) has licensed the two hospitals in the Waterbury area to operate a maximum of 704 beds and 68 bassinets. But over the last three years, the hospitals have gradually increased staffed beds to make available 63% or 447 beds in FY 2006 (Table 15). As a rule of thumb, hospitals obtain bed licenses to their maximum allowable capacity and staff beds based on demand and ability to staff them adequately.

Including critical care beds, about 70% of staffed beds in the area are medical or surgical. According to the two hospitals, in the last year, both have experienced increases in volumes associated with those beds, raising their medical/surgical occupancy rates to over 86% and ICU beds to over 80% for most of the year. Over a three-year period ending in FY 2006, both hospitals gradually added to the number of beds staffed for those services to bring the total to 323 (Table 15, see Appendices 1 and 2 for hospital details). But they staffed psychiatric beds at the same level in three consecutive years although they report occupancy at over 80%.

Table 15: Licensed and Staffed Acute Care Beds in Waterbury Area by Service Line, FYs 2004 - 2006

		Staffed Beds					Share of Staffed Beds	
Service Line	Licensed Beds	FY 2006	FY 2005	FY 2004	% of Licensed Beds Staffed in FY 2006	% of all Staffed Beds in FY 2006	St. Mary's Hospital	Waterbury Hospital
Medical/Surgical	479	260	257	249	**54%**	**58%**	40%	60%
OB/GYN	64	62	63	63	**97%**	**14%**	50%	50%
Psychiatry	50	42	42	42	**84%**	**9%**	29%	71%
Critical Care	75	63	55	55	**84%**	**14%**	68%	32%
Pediatric	36	20	20	20	**56%**	**4%**	50%	50%
Total Beds	**704**	**447**	**437**	**429**	**63%**	**100%**	45%	55%
Total Bassinets	**68**	**68**	**68**	**68**	**100%**	**n/a**	47%	53%

The high demands for medical/surgical, critical care and psychiatric beds are from:

- Growing demand for monitored beds at both hospitals due to an aging population with more complex medical conditions that require higher intensity nursing care;
- Systemic issues caused by difficulty in discharging patients to either extended care facilities or other next level of care resources. Delayed discharge of patients to step down

care because of insufficient availability of the next level of care in the community for both elderly and behavioral health patients; and

- Waterbury Hospital is the only provider of hospital inpatient behavioral health care to adolescents in mental health Region 5[10].

Both hospitals' ability to increase staffed beds to accommodate rising demand for medical, surgical and critical care beds is limited by factors either unique to the individual hospital or widespread in the hospital industry. Some limitations, which continue to exist, include:

- A decommissioned 27-bed unit at St. Mary's Hospital;
- Conversion of semi-private rooms to single occupancy rooms stemming from need to provide privacy and isolation for patients that require it at both hospitals.
- Physical plant constraints including aging building and inefficient configuration of nursing units;
- Restricted access to capital for renovating decommissioned units or converting administrative space to clinical space;
- Difficulty in recruiting additional and retaining existing staff; and
- Regulatory challenges.

In FY 2006, both St. Mary's Hospital and Waterbury Hospital held staffing levels for OB/GYN and pediatric beds consistent with prior years even though both hospitals continue to report low occupancy for the beds.

Based on the area towns identified, which constitutes over 80% of the hospitals' discharges, the area seems to have relatively more staffed medical and surgical acute care beds available per 100,000 of the population than the state as a whole, that is 209 versus 186 per 100, 000 (Table 16). Although psychiatric beds seem sufficient for the area, Waterbury is the sole provider of behavioral health care for residents less than 18 years old in Region 5 and the hospital has assigned five beds to the age group, already deemed inadequate for the region.[11]

Table 16: Licensed and Staffed Acute Care Bed Availability in the Waterbury Area by Service Line, FYs 2004 - 2006

			Waterbury Area			
Service Line	Licensed Beds	FY 2006 Staffed Beds	Census 2000 Population	Licensed Bed Availability per 100,000	Staffed Bed Availability per 100,000	CT Staffed Bed Availability per 100,000*
Medical/Surgical[1]	554	323	154,773	358	209	186
OB/GYN[2]	64	62	82,519	78	75	80
Psychiatry[3]	50	42	194,438	26	22	21
Pediatric[4]	36	20	51,520	70	39	33
Total Beds	**704**	**447**	**206,293**	**341**	**217**	**209**
Total Bassinets[5]	**68**	**68**	**2,568**	**2,648**	**2,648**	**-**

Source: *US Census 2000 & * Studying Health Care Utilization in Connecticut, A Report to the Governor and General Assembly.*
[1] Adults over 17 years old. Beds include critical care beds.
[2] Females over 17 years old.
[3] Ages 5 and over.
[4] Population under 18 years old (54,088) minus discharges reported for (5) below.
[5] Bassinets for both nursery and NICU. Population is three-year average number of discharges reported by the two hospitals for discharges assigned Diagnosis Related Group (DRGs) 385-391in the OHCA Acute Care Discharge Database.

B. Acute care inpatient utilization by service type

This section provides an overview of the inpatient (IP) services that Waterbury area residents utilized over the three-year period ending in FY 2006. It combines utilization at both hospitals to better assess the needs of the community overall.

Inpatient medical care is almost one-half of the services the two hospitals provide; surgical and maternity/pediatrics care each account for about one-quarter; and behavioral health is 5%. The two hospitals started a joint advance cardiac services program over a year ago, which generated an increase in volume that was offset by a decline in behavioral health care. The combined inpatient services provided grew by 2% although maternity/pediatric care accessed declined by 3% in FY 2005 (Table 17, see Appendices 3 and 4 for hospital details). The overall increase in discharges in the area was no different from state level increases. Annualized volumes for FY 2006 indicate a significant drop in behavioral health discharges (11%) while discharges for other services will be close to their FY 2005 levels altogether resulting in a 1% decline in inpatient care utilization for the area.

Table 17: Waterbury Area Hospitals Acute Care Discharges by Service Line, FYs 2004 - 2006

	Discharges				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	12,546	12,563	12,055	**12,388**	0	4	4
Surgical	7,548	7,527	7,352	**7,476**	0	2	3
Behavioral Health	1,538	1,721	1,650	**1,636**	-11	4	-7
Maternity/Pediatrics	5,930	5,942	6,118	**5,997**	0	-3	-3
Total	**27,562**	**27,753**	**27,175**	**27,497**	**-1**	**2**	**1**

By the end of FY 2006, although total medical and surgical discharges are expected to remain the same and behavioral health and maternity/pediatric days to reduce, the hospitals anticipate 3% and 10% increases in medical and surgical patient days respectively. The result is a net increase in patient days of 4% for the year and 5% over the three-year period (Table 18, see Appendices 5 and 6 for hospital details).

Table 18: Waterbury Area Hospitals Acute Care Days by Service Line, FYs 2004 - 2006

	Acute Care Days				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	63,472	61,732	58,829	**61,344**	3	5	7
Surgical	39,926	36,345	37,832	**38,034**	10	-4	5
Behavioral Health	11,206	11,893	11,364	**11,488**	-6	5	-1
Maternity/Pediatrics	15,802	15,969	15,980	**15,917**	-1	0	-1
Total	**130,406**	**125,939**	**124,005**	**126,783**	**4**	**2**	**5**

Costs per discharge for all services are rising at both hospitals. Inpatient medical care cost per discharge was higher at Waterbury Hospital while inpatient surgical care cost per discharge was higher at St. Mary's Hospital. But by the end of FY 2006, the costs for both services at the hospitals were almost similar, $8,302 and $15,269 at St. Mary's Hospital versus $8,323 and $15,236 at Waterbury Hospital (Table 19). The converging unit cost for those service lines is better illustrated by the patient resource usage indicator or case mix index which was higher in FY 2003 for Waterbury Hospital but reduced for the hospital for two consecutive years to become almost equivalent to St. Mary's Hospital in FY 2005, 1.3534 versus 1.3577 respectively (for hospital details see Appendix 7). On the other hand, cost per discharge for behavioral health and maternity/pediatric inpatient care continue to be lower at St. Mary's Hospital. Generally, some of the variations in cost are attributable to what is included in cost, which tend to vary from hospital to hospital.

Table 19: Waterbury Area Hospitals Acute Care Cost[1] Per Discharge by Service Line, FYs 2004 - 2006

	St. Mary's Hospital ($)				Waterbury Hospital ($)			
Service Line	FY 2006	FY 2005	FY 2004	3-yr Average	FY 2006	FY 2005	FY 2004	3-yr Average
Medical	8,302	7,043	6,189	**7,211**	8,323	7,779	6,926	**7,676**
Surgical	15,269	12,874	12,391	**13,507**	15,236	12,843	11,776	**13,311**
Behavioral Health	7,303	6,612	5,999	**6,648**	9,376	8,059	7,620	**8,301**
Maternity/Pediatrics	3,095	3,980	3,662	**3,553**	4,260	3,548	3,581	**3,773**
Total	**8,817**	**7,998**	**7,305**	**8,058**	**9,590**	**8,227**	**7,527**	**8,433**

[1] There may be a variation in the components of cost between hospitals.

Medical care, which showed a gain of $62 per case in FY 2005 is projected to convert to a loss of $127 per case in FY 2006; behavioral health care although not the most expensive service to provide, lost the hospitals the most money per discharge, at a loss of $1,805 per case in FY 2005 and is expected to almost double to $2,834 per case in FY 2006 (Table 20, see Appendices 8 and 9 for hospital details). Despite sporadic growth in surgical care, losses per case for the service continue to rise. Based on annualized figures, loss per case for all services will grow by 64% by the end of FY 2006.

Table 20: Waterbury Area Hospitals Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 - 2006

	Gain or Loss Per Discharge/Case ($)				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Medical	(127)	62	322	**82**	-306	-81	353
Surgical	(1,871)	(1,112)	(850)	**(1,282)**	68	31	55
Behavioral Health	(2,834)	(1,805)	(1,472)	**(2,015)**	57	23	48
Maternity/Pediatrics	(794)	(765)	(927)	**(830)**	4	-18	-17
Total	**(899)**	**(549)**	**(386)**	**(612)**	64	42	57

[1] The combined per case gain/loss is sum of total revenue for the two hospitals minus the sum of their total costs divided by sum of discharges from both hospitals.

C. Emergency Department utilization

Emergency Departments (ED) are an essential part of a health care system as they serve as the safety net for communities. For vulnerable populations, they can also be the primary mode of access to health care in general.

Between the two hospitals, the Waterbury area has 73 ED beds (Table 21); St. Mary's Hospital recently added eight of beds in response to continuous growth in volumes. Both hospitals experience "boarding" in the ED where patients wait over 12 hours for admission to an inpatient bed or transferred to mostly psychiatric facilities, throughout the year. Longer wait times and boarding occur mostly for medical/surgical, telemetry and psychiatric patients despite improvements in patient flow processes. The wait for inpatient admits is mostly related to staffing constraints or physical limitations to increase available beds.

Table 21: Waterbury Area Hospitals Emergency Department Beds, 2006

St. Mary's Hospital		Waterbury Hospital	
Description	Beds	Description	Beds
Treatment Room	24	Acute ER	21
Trauma room	2	Prompt Care	5
Behavioral Health	5	Behavioral Health	4
Urgi-care room	7	Surge (for high census & boarders)	5
Total	**38**	**Total**	**35**

Area residents recorded an average of 115,300 ED visits or 552 visits per 1,000 of their population per year (Table 22) which is over 1.3 times the average rate for the state and the nation,[12] an average that continues to rise from year to year. The high utilization rate may be associated with insufficient availability of primary care services in the area; increased demand on EDs to provide primary care after hours coverage; admission of physician referred patients through the ED because of limited capacity to accommodate direct admit patients; and increased patient disease acuity from lack of ongoing preventive care or management.

Table 22: Waterbury Area Hospital Emergency Department Utilization, FYs 2004 - 2006

Hospital		FY 2006	FY 2005	FY 2004	3-yr. Average
St. Mary's	Treated & Discharged[1]	56,170	55,165	52,044	54,460
	Treated & Admitted[1]	8,286	8,177	7,581	8,015
	All ED Visits	64,456	63,342	59,625	62,474
Waterbury	Treated & Discharged	43,360	45,506	44,581	44,482
	Treated & Admitted	8,828	8,126	8,075	8,343
	All ED Visits	52,188	53,632	52,656	52,825
Waterbury Area Hospitals	**Treated & Discharged**	**99,530**	**100,671**	**96,625**	**98,942**
	Treated & Admitted	**17,114**	**16,303**	**15,656**	**16,358**
	All ED Visits	**116,644**	**116,974**	**112,281**	**115,300**
ED Utilization Per 1,000		553	560	538	551

When a patient visits an ED, the patient is either "treated and discharged" or "treated and admitted" to inpatient care or transferred to other types of health care institutions. In the Waterbury area, an average of 16,358 or 14% of ED visits result in an acute care admission, which is similar to 15% in the state. Also similar to the state, inpatients admitted through the ED at the two hospitals have increased from one-third of all acute care inpatients in FY 2004 to one-half in FY 2006. In both instances, admissions through the ED have effectively replaced physician referrals as the primary source of admissions to acute care.

Some of the top ten primary reasons for ED visits for the "treated and discharged" probably could have been taken care of in a doctor's office or a primary care center providing one was available at onset of symptoms (for details see Appendices 10 and 11). The top ten primary reasons Waterbury area hospitals admitted ED patients to inpatient care were mostly cardiac, respiratory or infection related (for details see Appendix 12).

On average, Waterbury Hospital cost per ED per visit is almost 1.5 times St. Mary's cost (Table 23). According to the hospitals, the difference is in the items each hospital includes in its cost structure. For example, in this case St. Mary's Hospital excludes ED-related physician cost but accounts for it in the cost structure of its for-profit affiliate, the Franklin Medical Group, PC. Waterbury Hospital's cost structure also includes the cost of medical liability.

Table 23: Waterbury Area Hospital Emergency Department Cost[1] Per Treated and Discharged Visit, FYs 2004 - 2006

	Average Cost per Visit ($)			
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	290	290	242	**274**
Waterbury	484	454	444	**460**
Waterbury Area Hospitals	**374**	**364**	**335**	**358**

[1] There may be a variation in the components of cost between hospitals.

Similar to inpatient care services, both hospitals provide emergency services at a loss per visit; the three-year combined average loss was $17 per "treated and discharged" visit (Table 24). The losses are increasing from year to year. Waterbury Hospital experienced the higher losses per visit than St. Mary's Hospital.

Table 24: Waterbury Area Hospital Emergency Department Gain or Loss Per Treated & Discharged Visit, FYs 2004 - 2006

	Gain or Loss Per Discharged Visit ($)			
Hospital	FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	(22)	(15)	24	**(5)**
Waterbury[2]	(36)	(29)	(30)	**(32)**
Waterbury Area Hospitals	**(28)**	**(21)**	**(1)**	**(17)**

[1] For each cell, the combined per case gain/loss is sum of net revenues for the two hospitals minus the sum of total costs for the two divided by sum of discharges from both hospitals.

D. Outpatient services utilization

Outpatient (OP) services the two hospitals provide in the area include medical and dental clinics; behavioral health care and other OP care such as one-day surgery, radiology, laboratory, gastroenterology and other services.

i. Medical clinic utilization

Affiliates of each hospital own and operate the medical outpatient clinics for both hospitals.

Franklin Medical Group, PC (FMG) a for-profit entity, provides adult primary care in its Family Health Center, pediatric primary care in its Children's Health Center and dental care in the Dental Health Center for St. Mary's Hospital. On average, FMG records 47,996 visits per year at the three clinics combined (Table 25). In the last three years, area residents made the largest number of visits in FY 2005 at 50,174, but this dropped by 6% by the end of FY 2006.

Table 25: St. Mary's Hospital Medical Clinic Visits by Service Line, FYs 2004 - 2006

	Visits				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Family Health	21,830	25,313	22,927	**23,357**	-14	10	-5
Children's Health	17,732	18,146	17,524	**17,801**	-2	4	1
Dental	7,460	6,715	6,342	**6,839**	11	6	15
Total	**47,022**	**50,174**	**46,793**	**47,996**	-6	7	0

While visits to the clinics will drop in FY 2006, cost per visit will rise in each clinic to an average $132 for all clinics (Table 26). Except for dental care, cost per visit at each of the other two clinics was lowest at the three-year peak volumes.

Table 26: St. Mary's Hospital Clinics Cost per Visit by Service, FYs 2004 - 2006

	Cost Per Visit ($)				% Change		
Clinic Service	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
Family Health	140	117	125	**127**	20	-7	11
Children's Health	138	122	144	**134**	13	-15	-5
Dental	94	79	57	**78**	20	38	39
Total	**132**	**113**	**123**	**123**	16	-8	7

From year to year, FMG operated the three clinics at a loss per visit; by the end of FY 2006, loss per visit will increase by 10% to $77 (Table 27).

Table 27: St. Mary's Hospital Clinics Gain or Loss per Visit by Service, FYs 2004 - 2006

Clinic Service	Gain or Loss Per Encounter/Case ($)				% Change		
	FY 2006	FY 2005	FY 2004	3-Yr Average	05/04	06/05	06/04
Family Health	(93)	(89)	(89)	**(90)**	4	0	4
Children's Health	(69)	(55)	(79)	**(67)**	25	-31	-15
Dental	(51)	(40)	(35)	**(42)**	28	12	30
Total	**(77)**	**(70)**	**(78)**	**(75)**	10	-11	-2

Greater Waterbury Network, Inc owns Chase Outpatient Center and the HIV clinic; but the Greater Waterbury Management Resources, Inc. and Alliance Medical Group, PC operate the two clinics on behalf of Waterbury Hospital. The outpatient center provides primary care, neurology, orthopedics, podiatry and urology services and the other provides HIV-related medical services and counseling to the Waterbury area.

Together the two clinics record an average of 10,895 visits per year and the number of visits is expected to grow by 24% by the end of FY 2006 and 5% in the three-year period (Table 28).

Table 28: Waterbury Hospital Clinic Visits by Service Line, FYs 2004 – 2006

Clinic Service	Visits				% Change		
	FY 2006	FY 2005	FY 2004	3-Yr Average	05/04	06/05	06/04
Chase Outpatient Center	10,712	8,581	10,806	**10,033**	25	-21	-1
HIV	1,138	997	451	**862**	14	121	60
Total	**11,850**	**9,578**	**11,257**	**10,895**	24	-15	5

The Waterbury Hospital only provided revenue data for the two clinics because cost at service line level is not available; as a result, OHCA is unable to determine gain or loss per visit at this time.

ii. Behavioral health services utilization

Patients in need of behavioral health care who receive adequate and continuous outpatient care have a reduced tendency to require emergency or inpatient care; therefore, there is a community benefit associated with providing outpatient psychiatric care. The FMG provides adult behavioral and substance abuse care for St. Mary's Hospital, while Behavioral Health of Waterbury Hospital Mental Health Outpatient Services and Behavioral Health of Waterbury Hospital Mental Addiction Services, both owned by Waterbury Hospital, provide psychiatry and addiction treatment for adolescents and children (ten years and older), adults and geriatrics.

Over the three-year period, the psychiatric clinics operated by or on behalf of the two hospitals experienced some decline in number of cases and visits, the facilities treated an average of 12,344 cases in 33,536 visits or 3 visits per case (Table 29). Although Waterbury Hospital clinics treated the overwhelming majority, on average, St. Mary's cases visited the clinics three times as often.

Table 29: Waterbury Area Hospitals Outpatient Psychiatric Cases, Visits and Average Visits per Case, FYs 2004 - 2006

	Number of Cases				% Change		
Hospital	FY 2006	FY 2005	FY 2004	3-Year Average	06/05	05/04	06/04
St. Mary's	1,026	929	816	**924**	10	14	26
Waterbury	10,978	11,428	11,854	**11,420**	-4	-4	-7
Waterbury Area	**12,004**	**12,357**	**12,670**	**12,344**	-3	-2	-5
	Number of Visits				% Change		
Hospital	FY 2006	FY 2005	FY 2004	3-Year Average	06/05	05/04	06/04
St. Mary's	6,712	5,898	3,731	**5,447**	14	58	80
Waterbury	26,100	28,601	29,566	**28,089**	-9	-3	-12
Waterbury Area	**32,812**	**34,499**	**33,297**	**33,536**	-5	4	-1
	Average Visits/Case						
Hospital	FY 2006	FY 2005	FY 2004	3-Year Average			
St. Mary's	7	6	5	**6**			
Waterbury	2	3	2	**2**			
Waterbury Area	**3**	**3**	**3**	**3**			

The three-year average costs per visit to psychiatric clinics were similar, $161 for St. Mary's and $162 for Waterbury (Table 30). Prior to FY 2006, the cost of an outpatient psychiatric clinic visit at St. Mary's Hospital was at least 1.5 times higher than one at Waterbury Hospital, but in FY 2006 there was substantial decline in the cost at St. Mary's. Cost per case is higher at St. Mary's Hospital because of relatively more frequent of visits per case (Table 29). Generally, some of the variations in cost are attributable to what is included in cost; components of cost tend to vary from hospital to hospital especially in cases where affiliates provide the service on behalf of the hospital.

Table 30: Waterbury Area Hospitals Outpatient Psychiatric Cost Per Case or Visit, FYs 2004 - 2006

Hospital	Cost Per Case ($) FY 2006	FY 2005	FY 2004	3-Yr Average
St. Mary's	1,625	2,427	2,276	**950**
Waterbury	669	686	638	**398**
Hospital	**Cost Per Visit ($) FY 2006**	**FY 2005**	**FY 2004**	**3-Yr Average**
St. Mary's	248	382	498	**161**
Waterbury	281	274	256	**162**

[1] There may be a variation in the components of cost between hospitals.

Each hospital's affiliate provides outpatient psychiatric services at a loss per case; the average combined losses over the three-year period was $328 with most of the losses occurring at St. Mary's Hospital, because the hospital had higher average number of visits and per unit cost (Table 31). Losses per visit for the hospitals converge in FY 2006 at $115 for St. Mary's and $113 for Waterbury.

Table 31: Waterbury Area Hospital Outpatient Psychiatric Gain or Loss Per Case and Visit, FYs 2004 - 2006

Hospitals	Gain or Loss Per Case ($)[1] FY 2006	FY 2005	FY 2004	3-Yr Average	% Change 06/05	05/04	06/04
St. Mary's	(755)	(915)	(1,586)	**(1,053)**	7	-12	-7
Waterbury	(268)	(251)	(287)	**(269)**	3	-19	-16
Waterbury Area	**(310)**	**(301)**	**(370)**	**(328)**	-3	19	-13
Hospital	**Gain or Loss Per Visit ($) FY 2006**	**FY 2005**	**FY 2004**	**3-Yr Average**			
St. Mary's	(115)	(144)	(347)	**(179)**	12	-13	-2
Waterbury	(113)	(100)	(115)	**(109)**	5	-23	-20
Waterbury Area	**(113)**	**(108)**	**(141)**	**(121)**	-5	23	-17

[1] Combined per case gain/loss is sum of total net revenue for the two hospitals minus the sum of their total costs divided by sum of cases or visits from both hospitals.

iii. Other outpatient services utilization

Other outpatient services utilization based on data received from the two hospitals consist of services such as one-day surgery, radiology, laboratory, gastroenterology and other services. Ownership structures vary between hospitals and private practice physicians so the data may not be consistent or necessarily comparable.

In the three-year period combined other OP services declined by 6% (Table 32).

Table 32: Waterbury Area Hospitals Other Outpatient Utilization, FYs 2004 – 2006

Hospital	Visits				% Change		
	FY 2006	FY 2005	FY 2004	3-yr Average	06/05	05/04	06/04
St. Mary's	135,516	131,538	141,478	136,177	3	-7	-4
Waterbury	110,122	111,971	119,728	113,940	-2	-6	-8
Waterbury Area	**245,638**	**243,509**	**261,206**	**250,118**	1	-7	-6
Utilization Per 1,000	1,476	1,466	1,561	1,498			

Other OP services cost per visit at Waterbury was 1.5 times St. Mary's, although this may vary from service to service (Table 33).

Table 33: Waterbury Area Hospital Other Outpatient Cost Per Visit, FYs 2004 - 2006

Hospital	Cost Per Visit ($)			
	FY	FY 2005	FY 2004	3-yr Average
St. Mary's	224	230	214	**223**
Waterbury	363	354	320	**345**
Waterbury Area	**286**	**287**	**263**	**278**

[1] There may be a variation in the components of cost between hospitals.

Despite the declining volumes, both hospitals made some gains per case providing other outpatient services. The two hospitals made experienced gains per visit for three consecutive years with most of the gains occurring at St. Mary's Hospital, (Table 34)

Table 34: Waterbury Area Hospitals Other Outpatient Gain or Loss Per Visit, FYs 2004 - 2006

Hospital	Gain or Loss Per Visit ($)			
	FY 2006	FY 2005	FY 2004	3-yr Average
St. Mary's	25	13	32	**23**
Waterbury[2]	16	15	15	**15**
Waterbury Area Hospitals	**21**	**14**	**24**	**20**

[1] The combined per case gain/loss is sum of total revenue for the two hospitals minus the sum of their total costs divided by sum of discharges from both hospitals.

D. Payer reimbursement and mix

Hospital profitability relies significantly on a balance between patients covered by commercial/private insurance, government sponsored programs, such as Medicare, Medicaid or state or local programs in Connecticut such as State-Administered General Assistance (SAGA), and self-pay or uninsured patients. The driving force behind the gain or loss per case is the source of reimbursement.

Federal and state governments predetermine payment rates for Medicare and Medicaid patients, while hospitals negotiate reimbursement rates with private and commercial payers. In general, Medicaid rates do not fully cover cost while private or commercial programs traditionally reimburse at or above costs, depending on how the negotiated rates favor the hospitals.

In the Waterbury area, Medicare and private payers reimburse slightly above cost but reimbursement rates have been declining from year to year (Table 35). Currently, the two payers reimburse the two hospitals just enough to offset each other's underpayments. In FY 2005, Medicaid reimbursed less than one-half of St. Mary's Hospital's cost and less than 80% of Waterbury Hospital's.

Table 35: Waterbury Area Hospitals Primary Payer Payment to Cost, FYs 2003 - 2005

	St. Mary's Hospital			Waterbury Hospital			Connecticut		
	FY03	FY04	FY05	FY03	FY04	FY05	FY03	FY04	FY05
Ratio of cost to charges	0.44	0.44	0.47	0.42	0.36	0.34	0.49	0.46	0.44
Medicare payment to cost	1.03	1.12	1.03	0.89	0.95	0.96	0.97	0.97	0.97
Medicaid payment to cost	0.85	0.80	0.47	0.68	0.82	0.79	0.73	0.73	0.72
Private payment to cost	0.95	1.08	0.96	1.02	1.07	1.06	1.14	1.18	1.20

Source: *Office of Health Care Access Hospital Financial Stability Reports for multiple years*

i. Hospital payer mix

Commercial payers are the dominant primary payer in the Waterbury Area accounting for 41% of total patient volume all services combined. Medicare accounts for 30%, Medicaid for almost one-quarter and self-pay or the uninsured for 4% (Table 36). In fact, commercial payers are the leading primary payer (46%) in the sole profitable areas of service for the hospitals; other outpatient services, which include one-day surgery, radiology, laboratory, gastroenterology and all other services except ED and outpatient psychiatry. The payer mix varies between services and hospitals. EDs in the area have an unfavorable payer-mix with over one-half of their patient volume being either Medicaid-covered or self-pay or uninsured and an annually declining share of commercially-covered patients. Although both hospitals provide care to a large portion of uninsured patients, 9% for St. Mary's Hospital and 11% for Waterbury Hospital, St. Mary's Hospital treats a disproportionate share (49%) of Medicaid patients in the ED. The payer mix presented in Table 36 is directly and highly correlated to the demographic profile outlined in Section 3.0.

Table 36: Waterbury Area Hospitals Payer Mix by Department, FYs 2004 - 2006

Services	Primary Payer	St. Mary's (%)			Waterbury (%)			Waterbury Area Hospitals (%)		
		FY04	FY05	FY06	FY04	FY05	FY06	FY04	FY05	FY06
Inpatient Discharges	Medicare	42	43	43	44	43	43	43	43	43
	Medicaid	25	23	23	21	20	20	23	22	21
	Commercial	31	32	32	33	34	34	32	33	33
	Worker's Compensation	1	1	1	1	1	1	1	1	1
	Self-pay/uninsured	1	1	1	1	2	1	1	1	1
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Emergency Department Treated and Discharged Visits	Medicare	14	15	15	17	18	18	15	16	16
	Medicaid	49	46	43	34	33	32	42	40	38
	Commercial	26	27	29	36	37	37	30	32	33
	Worker's Compensation	2	2	3	3	3	3	2	3	3
	Self-pay/uninsured	9	9	10	11	10	10	10	10	10
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Outpatient Behavioral Health Visits	Medicare	9	13	9	46	47	45	43	44	42
	Medicaid	55	58	54	37	35	38	38	37	39
	Commercial	36	28	36	15	16	16	17	17	17
	Worker's Compensation	0	0	0	0	0	0	0	0	0
	Self-pay/uninsured	1	1	0	2	2	2	2	2%	2
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
All Other Outpatient Visits	Medicare	32	33	32	30	31	32	31	32	32
	Medicaid	17	17	16	18	18	18	18	18	17
	Commercial	47	47	46	45	45	45	46	46	45
	Worker's Compensation	1	1	3	1	1	1	1	1	2
	Self-pay/uninsured	2	2	3	5	5	4	4	3	4
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Total	**Medicare**	**28**	**28**	**28**	**32**	**33**	**33**	**30**	**31**	**31**
	Medicaid	**26**	**26**	**24**	**20**	**19**	**19**	**23**	**23**	**22**
	Commercial	**41**	**41**	**41**	**42**	**42**	**42**	**41**	**42**	**41**
	Worker's Compensation	**2**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	**2**
	Self-pay/uninsured	**4**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	**4**
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

ii. Medical clinics payer mix

Based on a three-year average, four of every five visits to St. Mary's Hospital medical clinics were Medicaid covered or self-pay or uninsured, 14% of the visits were commercially-covered and 7% were covered by Medicare (Table 37). An overwhelming majority of visits to the Children's Health and Dental clinics were Medicaid covered, while family health has seen a sharp rise in self-pay or uninsured visits for family health care.

Table 37: St. Mary's Hospital's Outpatient Medical Clinics Payer Mix, FYs 2004 - 2006

		St. Mary's Hospital			
Clinic Services	Primary Payer	FY 2006	FY 2005	FY 2004	3-yr Average
Family Health	Medicare	17%	14%	13%	14%
	Medicaid	58%	69%	73%	69%
	Commercial	11%	12%	10%	11%
	Self-pay	14%	5%	4%	6%
	Total	**100%**	**100%**	**100%**	**100%**
Children's Health	Medicare	0%	0%	0%	0%
	Medicaid	86%	83%	83%	83%
	Commercial	11%	15%	15%	14%
	Self-pay	3%	2%	2%	2%
	Total	**100%**	**100%**	**100%**	**100%**
Dental	Medicare	0%	0%	0%	0%
	Medicaid	96%	66%	66%	73%
	Commercial	3%	28%	28%	22%
	Self-pay	1%	6%	6%	5%
	Total	**100%**	**100%**	**100%**	**100%**
Clinic Total	**Medicare**	**6%**	**7%**	**7%**	**7%**
	Medicaid	**78%**	**73%**	**76%**	**75%**
	Commercial	**10%**	**15%**	**14%**	**14%**
	Self-pay	**6%**	**4%**	**4%**	**4%**
	Total	**100%**	**100%**	**100%**	**100%**

The Waterbury Hospital medical clinics payer mix is similar to St. Mary's Hospital's, primarily covered by Medicaid or self-pay or uninsured (Table 38).

Table 38 : Waterbury Hospital Outpatient Medical Clinics Payer Mix, FYs 2004 – 2006

Clinic	Primary Payer	Waterbury Hospital FY 2006	FY 2005	FY 2004	3 Yr Average
Chase Outpatient Center	Commercial	13%	9%	10%	11%
	Medicaid	54%	52%	54%	54%
	Medicare	24%	26%	25%	25%
	Self-pay/Uninsured	10%	12%	10%	11%
	Worker's Compensation	0%	0%	0%	0%
	Total	**100%**	**100%**	**100%**	**100%**
HIV Clinic	Commercial	20%	22%	31%	23%
	Medicaid	50%	44%	45%	47%
	Medicare	15%	14%	19%	16%
	Self-pay/Uninsured	15%	19%	5%	15%
	Worker's Compensation	0%	0%	0%	0%
	Total	**100%**	**100%**	**100%**	**100%**
Clinic Total	**Commercial**	**13%**	**10%**	**11%**	**12%**
	Medicaid	**54%**	**52%**	**54%**	**53%**
	Medicare	**23%**	**25%**	**24%**	**24%**
	Self-pay/Uninsured	**10%**	**13%**	**10%**	**11%**
	Worker's	**0%**	**0%**	**0%**	**0%**
	Total	**100%**	**100%**	**100%**	**100%**

5.0 Financial status of the hospitals at the end of FY 2006

Although by the end of FY 2006 St. Mary's Hospital decreased its operating losses, it continued to operate at a deficit, (3.7%) in FY 2006 compared to (10.02%) in FY 2005, (Table 1). Operating loss, for Waterbury Hospital more than tripled from the year before. For both hospitals, expenses continue to exceed revenues and since patient care is the primary source of operating revenue, the cost and the payer mix are critical to the bottom line.

Revenue from government payers (Medicare and Medicaid) to the two hospitals have dropped to 59% in FY 2006 while costs for patients covered by these payers continue to account for about 64% the costs of providing care (Table 39). Government underpayments to the hospitals are augmented by little or no revenues from self-pay patients who account for 2% of the cost of care. Revenues from patients covered by commercial and workers compensation payers although more than cover the costs of caring for those patients (about 41% versus 35% respectively) is still insufficient to make up for the deficit from government payers.

Table 39: Financial profile of St. Mary's Hospital and Waterbury Hospital, FYs 2004 – 2006

	St. Mary's Hospital			Waterbury Hospital		
Financial Statistics	2006	2005	2004	2006	2005	2004
Net Assets						
Hospital	($136,000)	$23,760,000	$26,430,000	$124,628,134	$126,535,925	$119,504,105
Health System	$1,424,000	$8,469,000	$16,197,000	$163,330,870	$166,079,218	$158,400,874
Hospital Net Revenue Payer Mix*						
Medicare	45%	46%	46%	45%	46%	45%
Medicaid	14%	14%	14%	12%	17%	14%
Commercial	37%	36%	37%	38%	34%	37%
Workers Compensation	4%	3%	3%	4%	1%	3%
Self Pay	0%	0%	0%	0%	2%	0%
	100%	**100%**	**100%**	**100%**	**100%**	**100%**
Hospital Cost Payer Mix*						
Medicare	44%	44%	44%	46%	46%	46%
Medicaid	20%	19%	19%	17%	18%	18%
Commercial	31%	33%	33%	34%	33%	33%
Workers Compensation	2%	2%	2%	1%	1%	1%
Self Pay	2%	2%	2%	2%	2%	2%
	100%	**100%**	**100%**	**100%**	**100%**	**100%**
Financial Indicators						
Current ratio	0.8	1.96	1.78	2.03	2.15	1.93
Days of expenses in accounts payable	72	71	69	42	47	56
Days cash on hand	1	3	5	20	34	42
Days of revenue in accounts receivable	38	48	60	49	42	37
Equity financing ratio	(13%)	3%	7%	35%	37%	36%

Source: *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2005, the hospitals' Audited Financial Statements 6 & *data submitted by the hospitals in response to the investigation.*

For consecutive years both hospitals experienced negative operating margins, a sign of financial distress. This is more apparent with St. Mary's Hospital whose rather low current liabilities to current asset ratio, 0.8 in FY 2006, put the hospital at a higher risk for technical insolvency[13] . The hospital's cash flow position worsened with the amount of cash on hand to meet its short-term obligations during the year dropping from three days in FY 2005 to one day in FY 2006. The median number of days of cash on hand for the state and the nation in FY 2005 were 37.6 and 25.8 days respectively and an increasing trend is more favorable. To improve cash flow, the hospital shortened the average time it took to collect revenues from billed patients by ten days down to 38 days but that was not enough to improve the average time it took to pay creditors, which increased by one day up to 72 days.

Over the last three years, Waterbury Hospital has experienced deterioration in its cash flows; the hospital's days of cash on hand have reduced from 42 days to 20 days, which is below state and national medians. This may relate to the fact that it took the hospital seven days more to collect revenues from billed patients on average, and it paid its creditors five days earlier than the year prior. However, Waterbury Hospital is at very low risk of technical insolvency indicated by its current assets to current liabilities ratio in FY 2006 of 2.03 which is above the median for the state and nation.

Appendix A

C.G.S. §19a-633

Investigative powers. The commissioner or any agent authorized by him to conduct any inquiry, investigation or hearing under the provisions of this chapter, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the office, the commissioner or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to him by the commissioner or his authorized agent or to produce any records and papers pursuant thereto, the commissioner or his agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

Appendix 1: Saint Mary's Hospital Licensed and Staffed Beds by Service Line, FYs 2004 - 2006

Service Line	Licensed Beds	Staffed Beds				% of Licensed Beds Staffed in FY 2006
		FY 2005	FY 2005	FY 2006	3-Yr Average	
Medical/Surgical	228	105	102	102	103	46%
OB/GYN	32	31	31	31	31	97%
Psychiatry	20	12	12	12	12	60%
Critical Care	55	43	35	35	38	78%
Pediatrics	12	10	10	10	10	83%
Total	**347**	**201**	**190**	**190**	**194**	**58%**
Total Bassinets	**32**	**32**	**32**	**32**	**32**	**100%**

Appendix 2: Waterbury Hospital Licensed and Staffed Beds by Service Line, FYs 2004 - 2006

Service Line	Licensed Beds	Staffed Beds				% of Licensed Beds Staffed in FY 2006
		FY 2006	FY 2005	FY 2005	3-Yr Average	
Medical/Surgical	251	155	155	147	152	62%
OB/GYN	32	31	32	32	32	97%
Psychiatry	30	30	30	30	30	100%
Critical Care	20	20	20	20	20	100%
Pediatrics	24	10	10	10	10	42%
Total	**357**	**246**	**247**	**239**	**244**	**69%**
Total Bassinets	**36**	**36**	**36**	**36**	**36**	**100%**

Appendix 3: Saint Mary's Hospital Acute Care Discharges by Service Line, FYs 2004 - 2006

	Discharges				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
Medical	6,000	5,702	5,467	**5,723**	5	4	9
Surgical	3,320	3,403	3,308	**3,344**	-2	3	0
Behavioral Health	602	590	574	**589**	2	3	5
Maternity/Pediatrics	3,044	2,570	2,739	**2,784**	18	-6	10
Total	**12,966**	**12,265**	**12,088**	**12,440**	6	1	7

Appendix 4: Waterbury Hospital Acute Care Discharges by Service Line, FYs 2004 - 2006

	Discharges				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3-Yr Average	06/05	05/04	06/04
Medical	6,546	6,861	6,588	**6,665**	-5	4	-1
Surgical	4,228	4,124	4,044	**4,132**	3	2	4
Behavioral Health	936	1,131	1,076	**1,048**	-17	5	-15
Maternity/Pediatrics	2,886	3,372	3,379	**3,212**	-14	0	-17
Total	**14,596**	**15,488**	**15,087**	**15,057**	**-6**	**3**	**-3**

Appendix 5: Saint Mary's Hospital Acute Care Days by Service Line, FYs 2004 - 2006

	Days				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 yr Average	06/05	05/04	06/04
Medical	29,890	27,678	26,297	**27,955**	8	5	12
Surgical	18,272	16,931	17,307	**17,503**	8	-2	5
Behavioral Health	3,864	3,709	3,588	**3,720**	4	3	7
Maternity/Pediatrics	7,966	6,781	7,008	**7,252**	17	-3	12
Total	**59,992**	**55,099**	**54,200**	**56,430**	**9**	**2**	**10**

Appendix 6: Waterbury Hospital Acute Care Days by Service Line, FYs 2004 - 2006

	Days				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 yr Average	06/05	05/04	06/04
Medical	33,582	34,054	32,532	**33,389**	-1	5	3
Surgical	21,654	19,414	20,525	**20,531**	12	-5	5
Behavioral Health	7,342	8,184	7,776	**7,767**	-10	5	-6
Maternity/Pediatrics	7,836	9,188	8,972	**8,665**	-15	2	-14
Total	**70,414**	**70,840**	**69,805**	**70,353**	**-1**	**1**	**1**

Appendix 7: Case Mix Index for St. Mary's and Waterbury Hospitals, FY 2003 - 2005

	FY 2006	FY 2005	FY 2004	FY 2003
St. Mary's	-	1.3577	1.3576	1.3733
Waterbury	-	1.3534	1.3848	1.4015

Source: *OHCA Hospital Budget System*
[1] Not yet available to OHCA.
Case mix index - measures the relative cost of treating patients at a hospital, the average cost is 1.0.

Appendix 8: Saint Mary's Hospital Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 – 2006

	Gain or Loss Per Discharge/Case ($)				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	69	431	617	**364**	-84	-30	-790
Surgical	(2,809)	(1,493)	(1,550)	**(1,947)**	88	-4	45
Behavioral Health	(2,543)	(2,162)	(1,594)	**(2,107)**	18	36	37
Maternity/Pediatrics	(561)	(1,275)	(1,298)	**(1,022)**	-56	-2	-131
Total	**(937)**	**(585)**	**(515)**	**(684)**	60	14	45

Appendix 9: Waterbury Hospital Acute Care Gain or Loss per Discharge or Case by Service Line, FYs 2004 – 2006

	Gain or Loss Per Discharge/Case ($)				% Change		
Service Line	FY 2006	FY 2005	FY 2004	3 Yr Average	06/05	05/04	06/04
Medical	(308)	(245)	76	**(160)**	25	-422	125
Surgical	(1,135)	(797)	(278)	**(743)**	42	187	75
Behavioral Health	(3,021)	(1,618)	(1,407)	**(1,964)**	87	15	53
Maternity/Pediatrics	(1,040)	(376)	(627)	**(663)**	177	-40	40
Total	**(866)**	**(521)**	**(282)**	**(553)**	66	85	67

Appendix 10: St. Mary's Hospital Top Ten Principal Reasons for Emergency Department Treated and Discharged Visits, FYS 2004 – 2006q1q2

ICD-9-CM Diagnosis Code	Code Description	FY 2006	FY 2005	FY 2004
465.9	Acute upper respiratory infections, unspecified site, not otherwise specified (NOS)	1,069	1,406	1,364
382.9	Otitis Media, NOS	832	1,590	1,458
34	Strep sore throat	637		
V58.3	Attending-surgical dressing/suture	617	1,050	862
79.99	Viral infection, NOS	595	1,010	1,096
462	Acute pharyngitis	529	809	760
599	Urinary tract infection, NOS	426	842	840
789	Abdominal Pain, Unspecified site	419		
493.92	Asthma NOS with acute exacerbation	409	868	794
786.59	Chest Pain Nec	406	846	772
847	Sprain Of Neck			818
786.5	Chest Pain NOS		867	797
784	Headache		876	
	Top Ten Total	**5,939**	**10,164**	**9,561**
	% of ED Treated & Discharged	**10%**	**18%**	**18%**

Appendix 11: Waterbury Hospital Top Ten Primary Reasons for Emergency Department Treated and Discharged Visits, FYs 2004 - 2006

ICD-9-CM Diagnosis Code	Diagnosis Description	FY 2006	FY 2005	FY 2004
789	Abdominal pain unspecified site	714	1,512	1,377
382.9	Otitis media NOS	519	1,008	1,072
780.6	Fever	502	950	844
786.5	Chest Pain NOS	493	932	834
465.9	Acute URI NOS	390	629	663
462	Acute pharyngitis	346		
786.59	Chest pain NEC	338	775	737
883	Open wound of finger	296	730	674
845	Sprain of ankle NOS	276	654	
784	Headache	275	638	
847.2	Sprain lumbar region			640
847	Sprain of neck		677	836
490	Bronchitis NOS			657
	Top Ten Total	**4,149**	**8,505**	**8,334**
	% of ED Treated & Discharged	**19%**	**19%**	**19%**

Appendix 12: Waterbury Hospitals Top Ten Primary Reasons for Emergency Department Treated and Admitted to Acute Care, FYs 2004 - 2006

ICD-9-CM Diagnosis Code	Diagnosis Description	FY 2006	FY 2005	FY 2004
486	Pneumonia	658	528	514
428	Congestive heart failure	517	455	377
786.59	Other chest pain	304	307	246
427.31	Atrial fibrillation	297	251	193
414.01	Coronary atherosclerosis	304	178	168
410.71	Subendocardial infarction	247	254	278
38.9	Unspecified septicemia	258		
518.81	Acute respiratory failure	256	193	150
599.0	Urinary tract infection, site not specified	262	224	204
780.2	Syncope and collapse	263		
276.5	Volume depletion		250	242
491.21	Obstructive chronic bronchitis with acute exacerbation			224
584.9	Acute renal failure, unspecified		173	
Total		**3,366**	**2,813**	**2,596**

Source: *OHCA Acute Care Discharge Database*

[1] *Snapshot: Connecticut's Health Insurance. Results of the Office of Health Care Access 2004 Household Survey. January 2005.*
[2] *Who are the Uninsured? Characteristics of Uninsured Workers in Connecticut.* Office of Health Care Access. January 2003.
[3] *Rising Acute Care Hospitals Inpatient Charges – FYs 1991 – 1999.* Office of Health Care Access. June 2001
[4] *Studying Health Care Utilization in Connecticut: Report to the General Assembly.* Office of Health Care Access. June 2006.
[5] Minorities include Blacks, American Indians or Eskimos or Aleuts, Hawaiian or Pacific Islanders, Asians, other non-whites and Hispanics or Latinos of any race.
[6] *Studying Health Care Utilization in Connecticut: Report to the General Assembly.* Office of Health Care Access. June 2006.
[7] *Snapshot: Connecticut's Health Insurance. Results of the Office of Health Care Access 2004 Household Survey. January 2005.*
[8] *Databook - Preventable Hospitalizations in Connecticut: Assessing Access to Community Health Services, FYs 2000 - 2004.* Office of Health Care Access. September 2005.
[9] *Health Care for Connecticut's Underserved Populations.* Connecticut Department of Public Health. November 2005.
[10] Department of Mental Health and Addiction Services (DHMAS) mental health service area which comprises of the towns of Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester, Wolcott, and Woodbury.
[11] *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children* .Submitted to the General Assembly. January 2006.
[12] *Studying Health Care Utilization in Connecticut: Report to the General Assembly.* Office of Health Care Access. June 2006.
[13] *Almanac of Hospital Financial and Operating Indicators, A comprehensive benchmark of the nation's hospitals.* Ingenix 2007.

Attachment B

State of Connecticut

THE CHARTIS GROUP, LLC. REPORT

Docket Number 06-30760-VST

Cristine A. Vogel
Commissioner
Office of Health Care Access

St. Mary's Hospital (SMH) and Waterbury Hospital (WH) jointly contracted with The Chartis Group, LLC. to conduct a market overview, a financial review and community needs assessment and present options in the planning efforts to integrate the hospitals.

The consultants projected the financial impact of different levels of possible integration:

Level 1: Administrative and Operational Support Integration only
Level 2: Limited Clinical Integration and Level 1
Level 3: Full Administrative and Clinical Integration

The consultant's model included integration expenses that would be necessary depending on the level of integration required. In summary, these expenses related to cost associated with:

A. Integration Costs: consulting and legal fees, public relations costs, reduction in workforce severance, etc.

B. IT Platform Alignment: Cerner rollout to SMH, fiber optic cable linkage, PACs, telecommunication system integration, etc.

C. Facility Renovation: Emergency Department, inpatient unit expansion, outpatient facilities, etc.

With the assumptions above, the consultants then estimated costs for each level of integration over 5 years:

	Level One ("Millions")	**Level Two** ("Millions")	**Level Three** ("Millions"
A. Affiliation Costs	$ 12.0	$ 17.0	$ 25.0
B. Technical Costs	$ 12.2	$ 12.2	$ 12.2
C. Facilities Costs	$ 1.0	$ 3.9	$ 62.2
	$ 25.2	**$ 33.1**	**$ 99.4**

All levels of integration show a positive financial gain 5 years out. There would be a significant spend down or depletion of Waterbury Hospital cash reserves to facilitate the affiliation. Therefore, WH would be at risk of violating some of its bond covenants and possibly alter its credit profile and its future access to capital.

Summary of Consultant's report:

- SMH is cash flow negative, has a drained balance sheet and is outside its Bond Covenants
- WH has a stronger Balance Sheet but faces income and cash flow challenges that will make it increasingly difficult to fund future capital requirements
- According to the report, it may take more than 10 years to get to the point where the combined entity could afford to build a new combined hospital
- A closer affiliation between WH and SMH can yield significant cost savings opportunity and long term financial benefit to the region's health care delivery system
- While full clinical integration (Level 3) might be too costly in the near term, Level 1 and Level 2 can provide ample net cash flow to stabilize operations and position the delivery system to move toward full clinical integration in the future
- SMH and WH have internal issues that would need to be addressed, such as: Catholic and Secular organizations, WH has a unionized workforce, SMH liabilities, and a general cultural divide between the two organizations.

StayWell
HEALTH CENTER

December 11, 2006

Cristine A. Vogel, Commissioner
State of Connecticut, Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Vogel:

Thank you for inviting StayWell Health Center to respond to the recent Draft Study that was completed on the two hospitals in Waterbury. We agree that there are some concerns with the structure of healthcare that impact our community. StayWell is committed to being a part of the solution so that our patients and our community can continue to have quality care that is accessible.

In the past, StayWell has partnered with both hospitals in many successful projects. Most recently we have been working on an integrated network of services for uninsured adults that includes enrollment in Pharmacy Assistance Programs, Linkage with Primary Care, Medicaid Eligibility Screening, Application Assistance and the pursuit of an Electronic Health Record.

However, we want to alert you to the many barriers to providing services that StayWell contends with because they will not make it easy to resolve the community-based issues of access that the Study discusses.

- We have difficulty getting access to Specialists who are not interested in seeing our patients. The low reimbursement rates for Title 18 and Title 19 for non-community health center providers has a trickle down effect on our patients. Not only is this barrier influenced by low reimbursement rates, but when patients have delayed care they become more complicated to manage and pose a greater malpractice risk. At StayWell, we repeatedly encounter patients who have suffered poorer outcomes either due to the lack of specialty access or due to a delay in seeking/receiving primary care because they were uninsured.

- StayWell has a base of $1 million in federal support through HRSA. Other community health centers on average are funded at a significantly higher amount. Federal support has not kept pace with the rapid growth in its client base that StayWell has experienced. In fiscal year 2000, StayWell provided 14,856 health care visits. Six years later, in fiscal year 2006, we provided 55,687 visits, a growth of 275%. StayWell employs 110 health professionals to care for these patients.

80 Phoenix Avenue ✝ Waterbury, CT 06702 ✝ Tel: (203) 756-8021 ✝ Fax: (203) 596-9038

- StayWell does receive funding from the State of Connecticut to assist with providing services to the uninsured. StayWell receives approximately $118,000 from the Department of Public Health on an annual basis to cover costs associated with the uninsured in the Adult Medicine and Dental Departments. This has been reduced over the years with a loss of over $100,000 to cover the costs of Pediatric uninsured services a few years ago. With our uninsured rate rising to 20% of all patient visits, this loss has been a struggle. Again, it is our understanding that our DPH funding for services to the uninsured is much lower than our colleagues throughout the State of Connecticut.

- There are commonalities in the struggles that our healthcare organizations face on a daily basis, primarily staffing. With the shortage in qualified nurses, we are frequently competing for staff. We have seen this to be the case for physicians also. Hiring culturally competent staff is always a struggle and then unfortunately added to the existing community shortages. Ultimately, staffing shortages impact access to care when special outreach services or walk-in hours need to be suspended due to inadequate staff to assign.

Thank you in advance for your consideration of the above-mentioned concerns that must be taken into account when designing a solution. Again, we look forward to continued conversation that will result in a solution for our patients and community.

Respectfully submitted,

Donald J. Thompson, MPS
President/CEO

cc: Robert Ritz
John Tobin
John Blair
Susan Cole England
Karen Roberts

State of Connecticut

HOSPITAL CLOSURES AND MERGERS

IN CONNECTICUT

Docket Number 06-30760-VST

Cristine A. Vogel
Commissioner
Office of Health Care Access

Attachment D

In 1990 Connecticut had 36 acute care general hospitals – today there are 30. The state has experienced the similar national trend with the decreasing number of acute care hospitals. The primary drivers of these closures and mergers are related to reimbursement, competition and shifting population demographics.

After reviewing the state's closures and mergers, it was apparent that each circumstance was different depending upon the financial strengths and weaknesses of the hospitals involved. In all of the mergers (in the cities of Bridgeport, Hartford and Meriden) one hospital was financially capable of absorbing the debt of the less viable hospital; and in no circumstances was the State of Connecticut financially responsible for the merger or closure activity.

Connecticut has experienced 6 mergers; one closure of a small rural community hospital; one acquisition and conversion of a small non-profit to the state's only for-profit hospital. The construction of a new children's hospital and a 94-bed community hospital were both results of mergers. Table 1 provides an overview of the closure and merger activity.

Table 1. Hospital Closures and Mergers in Connecticut

Year	Activity	Surviving Entity	Number of Licensed Acute-Care Hospitals
1990			36
1991	Meriden-Wallingford Hospital merges with WWII Memorial Hospital to form Veterans Memorial Medical Center	Veterans Memorial Medical Center	35
1993	Park City Hospital merges with Bridgeport Hospital	Bridgeport Hospital	34
1995	Mount Sinai Hospital merges with Saint Francis Hospital and Medical Center	Saint Francis Hospital and Medical Center	33
1996	Connecticut Children's Medical Center opens (consolidating services previously provided at three hospitals - Hartford, John Dempsey and Newington Children's Hospital) and succeeding Newington Children's Hospital	Connecticut Children's Medical Center	33
1997	Bankruptcy of Winsted Hospital	Winsted Health Center	32
1998	MidState Medical Center opens as successor to Veterans Memorial Medical Center	MidState Medical Center as successor to VMMC	32
1998	Saint Joseph's Hospital merges with Stamford Hospital	Stamford Hospital	31
2002	Not-for-profit Sharon Hospital acquired by for-profit Essent Healthcare (CT's first for-profit acute care hospital)	Sharon Hospital	31
2006	New Britain Hospital merges with Bradley Memorial Hospital	The Hospital for Central Connecticut	30

The one merger that closely resembles the circumstances with St. Mary's Hospital and the Waterbury Hospital would be the merger of Park City Hospital and Bridgeport Hospital. Below is a brief summary of facts:

Merger of Park City Hospital and Bridgeport Hospital

On March 30, 1993, OHCA issued a decision which authorized the merger of Park City Hospital into Bridgeport Hospital, with Bridgeport Hospital being the surviving entity.

The projects total capital expenditure was $14,327,000 plus $1,561,000 in capitalized financing, for a total capital expenditure of $15,888,000. The $14,388,000 Park City Hospital expenditure component was financed through CHEFA revenue bonds and the remaining $1,000,000 was equity-financed from internally generated funds.

Park City Hospital's Reasons for Merging:

- financial condition was negatively impacted by low and declining utilization of inpatient services
- inability to compete on services
- unable to renegotiate outstanding loan obligations or obtain new sources of capital
- reported long term debt payable of $810,777 and total assets of $23,547,109

Outcome of merger:

- Park City Hospital converted to an inpatient/outpatient rehabilitation center that provided inpatient psychiatric services (eventually relocated to Bridgeport Hospital)
- Park City Hospital's emergency services were replaced with primary care/walk-in center
- all acute care services provided at Park City Hospital (with the exception of ambulatory surgery) would be provided at Bridgeport Hospital site
- the merger resulted in the termination of 194 acute care beds

STATE OF CONNECTICUT

Report of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Group

March 2007

Prepared for:

Cristine A. Vogel, Commissioner
Office of Health Care Access

I. Background

In January 2006, the *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children* was issued. The report was prepared in response to Public Act 05-280, "An Act Concerning the Expenditures of the Department of Social Services." The report examined the challenges faced by the 31 acute care hospitals in Connecticut in providing inpatient behavioral health services to pediatric[1] patients, particularly in Mental Health Region 5 (Region 5). Currently, statewide only four of the hospitals have inpatient psychiatric units for children (ages 0 to 12) and six for adolescents (ages 13 to 17). Although not all hospitals have inpatient pediatric behavioral health services, hospitals attempt to accommodate these pediatric patients either in other units within the hospital or transfer them to other facilities for inpatient care.

The committee was to focus on the existing situation in Region 5 which has six acute care hospitals, Charlotte Hungerford, New Milford, Sharon, Danbury, St. Mary's and Waterbury, but only five beds for adolescent behavioral health patients at Waterbury Hospital and none at all for children in any of the hospitals (see Table 1). Also, there are no freestanding psychiatric hospitals in the region. According to the committee's report, in 2004, at least 200 the pediatric patients from the region had to access needed acute inpatient psychiatric care outside the region.

Table 1: CT acute care pediatric behavioral health beds, FY 2004

	# of Operational Beds					
Acute Care Hospitals	Age 0 - 12	Age 13 - 17	Swing beds	Age 1 - 17	Location	Region
Hospital of Saint Raphael	10	5	5	20	New Haven	2
Yale New Haven Psychiatric Hospital	15	14	0	29	New Haven	2
St. Francis Medical Center[2]	12	8	0	20	Hartford	4
Hartford/Institute of Living/CT Children's	9	13	0	22	Hartford	4
Manchester Hospital[3]	0	10	0	10	Manchester	4
Waterbury Hospital	0	5	0	5	Waterbury	5
Sub-Total	**46**	**55**	**5**	**106**		
Psychiatric Hospitals						
Public						
Riverview Children & Youth[4]	-	-	85	85	Middletown	2
Sub-Total	**0**	**0**	**85**	**85**		
Free-standing						
Hall-Brooke Behavioral Health Services	-	-	20 - 34	20 – 34	Westport	1
Silver Hill Hospital	0	10	0	10	New Canaan	1
Natchaug Hospital	6	12	3	21	Mansfield	3
Stonington Institute	0	4	0	4	N. Stonington	3
Sub-Total	**6**	**26**	**23 - 37**	**55 – 69**		
Statewide	52	81	113 - 127	246 - 260		

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Table 2, page 10.*
[1] Hospitals swing beds between the two age groups on as needed basis.
[2] Physical capacity is 23 beds.
[3] Survey was not administered to hospital.
[4] CT Department of Children and Families (DCF) provided the information; the facility has 12 additional sub-acute care beds.

[1] Under 18 years old.

In accordance with Public Act 05-280, the committee's report contains recommendations concerning the expansion of licensed hospital psychiatric inpatient bed capacity for children in Region 5. These recommendations are:

1. *Increase the number of acute care general hospital and/or psychiatric hospital beds and Psychiatric Residential Treatment Facility (PRTF) beds for children and adolescents in Region 5 based on the process outlined in Recommendation # 2.*

2. *The commissioner or designee of the Office of Health Care Access (OHCA) will convene an implementation group including the six general hospitals in Region 5, other behavioral health service providers to Region 5 residents under the age of 18, and representatives of state agencies for input on the appropriate number and location of beds. Execution of the group's proposal(s) will be subject to Certificate of Need (CON) authorization.*

To fulfill these recommendations, the Office of Health Care Access established an Implementation Group consisting of representatives of the six general hospitals in the region and of the Department of Children and Families (DCF), the Department of Social Services, Wellspring Foundation, the Child Guidance Clinic of Waterbury and the Northwest Center for Family Services and Mental Health (see Attachment 1).

The Implementation Group, which met three times during the summer and autumn, reviewed the most current pediatric inpatient behavioral health utilization data available to develop recommendations for the region. This report presents the recommendations about the appropriate number and locations of acute care, PRTF and emergency crisis stabilization beds needed in the region to facilitate patient access and transfer to appropriate levels of care and reflects the opinion of the majority of the group.

II. Implementation Group Recommendations and Rationale

Recommendation 1: Any Certificate of Need application for adding to behavioral health pediatric beds in Region 5 must include a plan for coordinating proposed additions with existing community-based services.

The overriding concern of the group is that an evaluation to establish the appropriate number of acute care beds should be system-based and not done in a vacuum. The behavioral health system includes emergency, acute and step down levels of care, all of which needed to be evaluated concurrently and any changes to be implemented should be coordinated with existing community-based services.

Recommendation 2: An additional 20 to 30 acute care general hospital and/or psychiatric hospital beds are required in Region 5. In order to provide developmentally appropriate care for children and adolescents, the additional beds should be allocated to two discrete units, one for children (up to 12 years old) and one for adolescents (13 – 18 years old).

According to the Committee's January 2006 report, there are 2.1 acute care pediatric behavioral health beds available per 10,000 residents under age 18 in Connecticut, but only 0.3 per 10,000 for the same age cohort in Region 5 (see Table 2). This demonstrates that Region 5 has substantially lower number of beds available for its pediatric population than the state in general. As a result, hospitals in the region admit children needing inpatient behavioral health services to general pediatric and adolescent units and adolescents to adult psychiatric and medical/surgical units; and the remaining are transferred or referred to hospitals located elsewhere in Connecticut or out-of-state. Currently, about one-half of the pediatric patients transferred out-of-state for behavioral health services are from Region 5. Area hospitals transferred one-third of pediatric patients from the region to other acute care providers in Connecticut for acute behavioral health treatment.

Table 2: Pediatric acute care behavioral health bed availability

Geographical Location	Regions	Acute Care Beds*	Share	Bed per 10,000 of child population
Southwest	1	44	25%	2.6
South Central	2	49	28%	2.6
Eastern	3	25	14%	2.6
North Central	4	52	30%	2.2
Northwest	5	5	3%	0.3
Statewide		**175**	**100%**	**2.1**

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Table 3, page 11.*

* Includes beds in acute care psychiatric units and freestanding psychiatric hospitals.

Patients receiving behavioral health treatment benefit most when their families are involved. Hence, additional acute care beds should be located in the region to improve families' ability to participate in care. In the absence of a state adopted standard bed need methodology, the group applied the statewide standard of 2.1 beds per 10,000 to the pediatric population of Region 5, of 149,927 based on Census 2000, to determine the maximum number of beds the area needs. Based on this methodology, there should be up to 31 beds in total in the region, or about 26 new beds given that five already exist in Waterbury. According to the experts in the group, a 10 to 15-bed unit is the most efficient and clinically appropriate size for an acute care behavioral health unit. The treatment of children and adolescents in the same milieu is developmentally inappropriate and may be counter-therapeutic. Consequently, the group recommends establishing two discrete units in the region, with a combined capacity of 20 to 30 new acute beds.

Recommendation 3: Locate any additional acute care pediatric psychiatric units in one of the three major population centers in Region 5; Danbury, Torrington and Waterbury.

Region 5 is a geographically large and diverse area that consists of 43 cities and towns. Table 3 is an analysis of acute care hospital Region 5 pediatric behavioral health discharges by town of origin. The data indicate that the majority of discharges and their associated patient days are from three metropolitan areas, Waterbury (27% and 33%), Torrington (8% and 12%) and Danbury (11% and 7%). In order to enhance access to acute programs, the group recommends the location of any additional programs in one of the three metropolitan areas.

Table 3: Region 5 Average Annual Acute Care Pediatric Behavioral Health[1] Discharges and Days by Town of Origin: SFYs 2004 - 2006q1-q3

	Children Ages 0 - 12	Adolescents Ages 13 - 17	Ages 0 - 17
Town of Origin	**Discharges = 86**	**Discharges = 234**	**Discharges = 320**
Waterbury	35%	24%	27%
Danbury	16%	9%	11%
Naugatuck	6%	7%	7%
Torrington	11%	7%	8%
Cheshire	5%	6%	6%
All other towns in region[2]	27%	48%	42%
Total	**100%**	**100%**	**100%**
Town of Origin	**Patient Days = 1,777**	**Patient Days = 2,053**	**Patient Days = 3,830**
Waterbury	47%	21%	33%
Torrington	15%	9%	12%
Cheshire	6%	10%	8%
Naugatuck	4%	10%	7%
Danbury	9%	5%	7%
All other towns in region[2]	20%	46%	34%
Total	**100%**	**100%**	**100%**

Source: *CT Office of Health Care Access Acute Care Discharge Database*

[1]Acute care hospitals' behavioral health discharges assigned Diagnosis Related Group (DRG) 424 to 437 or 521 to 523.

[2]For this purpose, discharges and patient days for the other 37 towns in the region were not significant individually.

Recommendation 4: Establish fifteen to twenty five Psychiatric Residential Treatment Facility (PRTF) beds in Region 5. These beds should be located in proximity to existing beds or as part of the establishment of a new program or facility, which includes acute beds.

Psychiatric residential treatment facilities (PRTFs) provide inpatient psychiatric care to Medicaid-covered patients under 21 years old. PRFTs facilitate acute care hospitals' patient "throughput" to ease system gridlock and "boarding" in the EDs.

In SFY 2004, over one-half (or 167) of acute care inpatient transfers to another type of institution were Medicaid beneficiaries who might have been better served by a step down level of care at facilities such as a PRTF or community-based alternatives;[2] this is an average of 14 patients per month. According to data from the Connecticut Behavioral Health Partnership (CT BHP) at four points in time for each month between September and November of 2006, on average 9.1 patients from the region were placed in mostly non-area PRTFs (Table 4). The highest number of patients placed within a month during the period was 11.5.

Table 4: Region 5 PRTF average admissions from September to November 2006

Region 5 Hospitals	Average # in all PRTFs	Average # in Wellspring	Average # in Non-Area PRTFs
Danbury	0.7	0.1	0.7
Charlotte Hungerford	4.0	1.5	3.0
Waterbury	4.5	2.0	3.4
St Mary's			
Total	**9.1**	**3.6**	**7.1**

Source: Department of Social Services Region 5 hospital and PRTF admits under the CT BHP between September and November 2006 taken at four points in time per month.

Within a month, an average of 1.5 patients awaited placement in a PRTF. The highest number of patients who awaited placement in the three-month period was 2.0.

In all, there was an average of 10.6 PRTF placements needed in the region during the three months. The highest number of placement needed within a month was 12.75. This means, between 50 and 60 percent of the region's acute care pediatric patients admitted during the period, required placement in a PRTF after acute care. The need for a PRTF level of care has increased with Wellspring's decision to discontinue its PRTF service in November 2006.

[2] *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children*. Submitted to the Connecticut General Assembly. January 2006. Ibid.

Emergency Crisis Stabilization Beds

In evaluating the needs of the region, the group discussed the feasibility of establishing emergency crisis stabilization beds (ESC) as part of the continuum of care. ECS beds are used for managing demand spikes, extended patient observation and minimizing "boarding" or patients waiting in the ED for more than 23 hours before admission to an inpatient bed or discharged to the community. Based on the committee's report, in FY 2004, hospitals in Region 5 evaluated 660 children and adolescents with a behavioral health diagnosis in the ED before transferring them to inpatient acute care. As many as one-quarter of those patients, waited in the ED for over 23 hours before the inpatient admission (see Table 3); [3] that is, an average of 15 boarders per month.

Table 3: Number of pediatric behavioral health patients evaluated in Region 5 Emergency Departments and length of stay in hours prior to inpatient admission, FY 2004

	Ages 0 – 12		Ages 13 – 17		Age 0 – 17	
	≤ 23 hours	> 23 hours	≤ 23 hours	> 23 hours	≤ 23 hours	> 23 hours
Charlotte Hungerford	56	6	149	32	205	38
Danbury	27	0	122	6	149	6
New Milford	2	0	8	0	10	0
Sharon	0	0	2	0	2	0
St. Mary's	0	56	0	74	0	130
Waterbury[1]	35	4	77	3	112	7
Total	**120**	**66**	**358**	**115**	**478**	**181**

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children.* Submitted to the Connecticut General Assembly. January 2006. Table 6, page 15.
[1] One adolescent outlier spent 170 hours in ED.

Assuming an average stay of 48 hours in the ED for those boarders, then the average daily census is one. According to information provided by DSS, a hospital based ED affiliated crisis unit is only economically viable if it serves more than 800 to 1,000 pediatric patients per year with an average overnight census of three or more patients. Therefore, currently there is not sufficient need to sustain a hospital based crisis stabilization unit in the region. The additional acute care and PRTF beds will be enough to handle potential demand spikes and extended stays, thus eliminate boarding.

[3] Ibid.

Attachment 1

Region 5 Pediatric Inpatient Psychiatric Services Implementation Workgroup

The membership of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Workgroup included the following persons:

1. Susan Cole, Director of Certification, Financial Analysis and Forecasting & Chair	Office of Health Care Access
2. Mark Schaefer, Ph.D., Director, Medical Policy and Behavioral Health, Medical Care Administration	Department of Social Services
3. Karen Andersson	Department of Children and Families
4. Peter Johnson, Ph.D.	Department of Children and Families
5. Dr. Charles Herrick, Medical Director, Inpatient Psychiatric Services	Danbury Hospital
6. Dr. Steven Singer, Chief of Psychiatry	Charlotte Hungerford Hospital
7. Thomas Narducci, LCSW	Charlotte Hungerford Hospital
8. Maureen Salerno, Director of Social Work	New Milford Hospital
9. Jena Brebbia, LCSW	Sharon Hospital
10. Dr. Peter Jacoby, Chairman of Emergency Services Department	St. Mary's Hospital
11. Doreen Elnitsky, Administrative Director, Behavioral Health	Waterbury Hospital
12. Tom Czarkosky, Manager, Child & Adolescent Behavioral Health Services	Waterbury Hospital
13. Gary Steck, Executive Director	Child Guidance Clinic of Waterbury
14. Herb Hall	Wellspring Foundation, Inc.
15. Donna Campbell	Northwest Center for Family Services and Mental Health

Staff to the Implementation Group

1. Olga Armah, Associate Research Analyst, Research and Evaluation	Office of Health Care Access
2. Steven Lazarus, Associate Health Care Analyst, Certification, Financial Analysis and Forecasting	Office of Health Care Access

EXHIBIT Q5-2

REPORTS BY KAUFMAN HALL AND PRICEWATERHOUSE COOPERS

Financial Plan

Waterbury, Connecticut / December 17, 2010

DRAFT FOR DISCUSSION
PURPOSES ONLY

KaufmanHall

Financial Strategies for Healthcare
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Revisions to Baseline Model

Revisions to Baseline Model

- For the revised baseline model, PWC's estimate of a reduction in net revenue of $12.5 million in FY 2011 compared to budget has been incorporated.
- Cost reductions related to a drop in surgical cases for FY 2011 of $4.2 million (75% of the net revenue drop of $5.6 million) have also been included.
- In FY 2012, an additional $1 million has been included for additional Federal stimulus monies for Information Technology beyond the $462K included in the FY 2011 budget.

Revised Baseline Model

The Waterbury Hospital Revised Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$254.8	$258.1	$264.9	$273.5	$282.2	$291.4
Operating Income	----	----	----	($9.2)	($7.6)	($9.0)	($8.9)	($9.1)	($9.2)
Operating EBIDA	----	----	----	$2.2	$1.9	$2.5	$3.6	$4.6	$5.9
Excess Income	----	----	----	($3.9)	($1.6)	($3.1)	($3.2)	($3.6)	($3.8)
Cash Flow (Net Inc + Depr)	----	----	----	$5.7	$7.3	$7.3	$8.2	$9.1	$10.2
Unrestricted Cash	----	----	----	$34.7	$28.2	$22.5	$16.1	$9.2	$1.6
Total Debt	----	----	----	$20.2	$26.2	$25.7	$25.2	$24.7	$24.2
Capital Expenditures	----	----	----	$7.1	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.5%	-2.9%	-3.3%	-3.2%	-3.2%	-3.1%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.9%	0.7%	0.9%	1.3%	1.6%	2.0%
Excess Margin	3.0%	1.6%	2.3%	-1.5%	-0.6%	-1.1%	-1.1%	-1.2%	-1.3%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.6	4.1	5.3	5.9	6.4	7.1
Debt to Capitalization	36.6%	40.1%	43.1%	30.9%	37.5%	38.9%	40.4%	42.3%	44.8%
Debt to Cash Flow	----	----	----	2.7	3.3	3.1	2.7	2.4	2.2
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	171.4%	107.6%	87.3%	63.9%	37.1%	6.8%
Days Cash on Hand (days)	176.3	125.7	125.1	48.5	39.3	30.4	21.2	11.7	2.0
Days in A/R, net	47.4	45.5	45.1	45.6	45.6	45.6	45.6	45.6	45.6
Other									
Average Age of Plant	10.1	10.0	10.3	22.3	25.0	22.6	21.4	20.4	19.4
Compensation Ratio	50.9%	54.2%	49.0%	58.6%	60.3%	59.8%	59.2%	58.6%	58.0%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	74.2%	247.2%	120.0%	120.0%	120.0%	120.0%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

Greater Waterbury Health Network, Inc. and Subsidiaries Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$259.8	$263.2	$270.1	$278.8	$287.6	$297.0
Operating Income	----	----	----	-$9.8	-$8.2	-$9.6	-$9.6	-$9.8	-$9.9
Operating EBIDA	----	----	----	$1.9	$1.7	$2.2	$3.3	$4.3	$5.5
Excess Income	----	----	----	-$3.9	-$1.0	-$2.5	-$2.6	-$3.0	-$3.2
Cash Flow (Net Inc + Depr)	----	----	----	$6.0	$8.1	$8.1	$9.1	$9.9	$11.0
Unrestricted Cash	----	----	----	$58.3	$52.5	$47.6	$42.0	$35.9	$29.1
Total Debt	----	----	----	$21.8	$27.7	$27.2	$26.7	$26.1	$25.5
Capital Expenditures	----	----	----	$5.6	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.6%	-3.0%	-3.4%	-3.3%	-3.3%	-3.2%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.7%	0.6%	0.8%	1.1%	1.4%	1.8%
Excess Margin	3.0%	1.6%	2.3%	-1.4%	-0.4%	-0.9%	-0.9%	-1.0%	-1.0%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.5	4.2	5.4	5.9	6.4	7.0
Debt to Capitalization	36.6%	40.1%	43.1%	23.8%	29.8%	30.2%	30.7%	31.3%	32.1%
Debt to Cash Flow	----	----	----	2.8	3.1	2.9	2.6	2.4	2.1
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	285.8%	193.2%	178.5%	161.0%	140.5%	116.8%
Days Cash on Hand (days)	176.3	125.7	125.1	78.8	70.8	62.2	53.5	44.4	35.1
Days in A/R, net	47.4	45.5	45.1	45.8	45.8	45.8	45.8	45.8	45.8
Other									
Average Age of Plant	10.1	10.0	10.3	22.0	24.6	22.3	21.2	20.2	19.3
Compensation Ratio	50.9%	54.2%	49.0%	58.8%	60.5%	60.0%	59.4%	58.8%	58.2%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	56.6%	241.3%	117.5%	117.8%	118.0%	118.2%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

Productivity Improvements

Productivity Improvements

FTE's were reduced gradually to achieve an FTE per AOB level of 4.80 by 2015 as follows:

	FTE's	FTE Change	FTE's per AOB	Compensation Ratio
2008	1,618.7		5.25	59.9%
2009	1,589.1		5.42	55.6%
2010	1,513.0		5.91	58.6%
2011 Budget	1,507.3		5.88	60.3%
2011 Revised	1,487.2	(20.1)	5.80	59.5%
2012	1,429.5	(57.7)	5.55	56.7%
2013	1,373.4	(56.1)	5.30	53.8%
2014	1,313.4	(60.0)	5.05	50.9%
2015	1,256.0	(57.4)	4.80	48.1%

The Waterbury Hospital Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$254.8	$258.1	$264.9	$273.5	$282.2	$291.4
Operating Income	----	----	----	($9.2)	($5.5)	($0.4)	$6.2	$13.3	$20.5
Operating EBIDA	----	----	----	$2.2	$4.0	$11.1	$18.8	$27.0	$35.5
Excess Income	----	----	----	($3.9)	$0.5	$5.8	$12.8	$20.6	$29.0
Cash Flow (Net Inc + Depr)	----	----	----	$5.7	$9.5	$16.2	$24.3	$33.3	$43.0
Unrestricted Cash	----	----	----	$34.7	$30.1	$32.7	$41.7	$58.3	$82.9
Total Debt	----	----	----	$20.2	$26.2	$25.7	$25.2	$24.7	$24.2
Capital Expenditures	----	----	----	$7.1	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.5%	-2.1%	-0.1%	2.2%	4.6%	6.9%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.9%	1.5%	4.1%	6.7%	9.4%	11.9%
Excess Margin	3.0%	1.6%	2.3%	-1.5%	0.2%	2.1%	4.5%	7.0%	9.4%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.6	5.2	10.9	16.0	21.7	27.8
Debt to Capitalization	36.6%	40.1%	43.1%	30.9%	36.4%	33.3%	28.2%	22.6%	17.5%
Debt to Cash Flow	----	----	----	2.7	2.6	1.5	1.0	0.7	0.5
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	171.4%	115.0%	127.0%	165.4%	235.7%	342.3%
Days Cash on Hand (days)	176.3	125.7	125.1	48.5	42.3	45.7	58.1	81.0	114.8
Days in A/R, net	47.4	45.5	45.1	45.6	45.6	45.6	45.6	45.6	45.6
Other									
Average Age of Plant	10.1	10.0	10.3	22.3	25.0	22.6	21.4	20.4	19.4
Compensation Ratio	50.9%	54.2%	49.0%	58.6%	59.5%	56.7%	53.8%	50.9%	48.1%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	74.2%	247.2%	120.0%	120.0%	120.0%	120.0%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

Greater Waterbury Health Network, Inc. and Subsidiaries Baseline Projections

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Actual 2010	Year ending September 30, Budget 2011	Projected 2012	2013	2014	2015
Net Patient Service Revenue	$248.2	$250.1	$177.0	$259.8	$263.2	$270.1	$278.8	$287.6	$297.0
Operating Income	----	----	----	-$9.8	-$6.1	-$1.0	$5.6	$12.6	$19.7
Operating EBIDA	----	----	----	$1.9	$3.8	$10.8	$18.4	$26.7	$35.1
Excess Income	----	----	----	-$3.9	$1.1	$6.4	$13.4	$21.2	$29.6
Cash Flow (Net Inc + Depr)	----	----	----	$6.0	$10.3	$17.0	$25.1	$34.1	$43.8
Unrestricted Cash	----	----	----	$58.3	$54.5	$57.8	$67.6	$85.0	$110.3
Total Debt	----	----	----	$21.8	$27.7	$27.2	$26.7	$26.1	$25.5
Capital Expenditures	----	----	----	$5.6	$22.0	$12.4	$13.7	$15.2	$16.8
Profitability									
Operating Margin	2.1%	1.6%	2.3%	-3.6%	-2.2%	-0.4%	1.9%	4.2%	6.4%
Operating EBIDA Margin	9.9%	8.1%	9.3%	0.7%	1.4%	3.9%	6.4%	8.9%	11.4%
Excess Margin	3.0%	1.6%	2.3%	-1.4%	0.4%	2.2%	4.5%	6.9%	9.3%
Debt Position									
Debt Service Coverage	3.2	2.4	3.0	2.5	5.2	10.5	15.2	20.3	25.9
Debt to Capitalization	36.6%	40.1%	43.1%	23.8%	29.1%	26.8%	23.3%	19.2%	15.4%
Debt to Cash Flow	----	----	----	2.8	2.5	1.5	1.0	0.7	0.6
Liquidity									
Cash to Debt	117.4%	99.3%	88.2%	285.8%	200.4%	216.8%	259.0%	332.8%	442.3%
Days Cash on Hand (days)	176.3	125.7	125.1	78.8	74.0	78.0	90.9	113.8	147.2
Days in A/R, net	47.4	45.5	45.1	45.8	45.8	45.8	45.8	45.8	45.8
Other									
Average Age of Plant	10.1	10.0	10.3	22.0	24.6	22.3	21.2	20.2	19.3
Compensation Ratio	50.9%	54.2%	49.0%	58.8%	59.7%	56.9%	54.1%	51.3%	48.6%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	56.6%	241.3%	117.5%	117.8%	118.0%	118.2%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

Appendix

Historical Credit Profile

Statement of Operations

- For purposes of comparability to the rating agency benchmarks, certain revenues classified as Other Operating Revenue in the audited financial statements have been reclassified to Non-Operating Revenue.
- Specifically, Investment Related Income, Unrestricted Gifts and Bequests, and Net Assets Released from Restrictions have been moved to Non-Operating Revenue.
- Unrealized gains or losses are excluded from the Statement of Operations.

The Waterbury Hospital Historical Credit Profile

($ in millions)	S&P[A] A-	S&P[A] BBB+	S&P[A] BBB	Year ending September 30, Actual 2008	2009	2010
Net Patient Service Revenue	$248.2	$250.1	$177.0	$235.3	$253.5	$254.8
Operating Income	----	----	----	($14.0)	($6.4)	($9.2)
Operating EBIDA	----	----	----	($2.3)	$4.7	$2.2
Excess Income	----	----	----	($8.4)	$0.5	($3.9)
Cash Flow (Net Inc + Depr)	----	----	----	$1.8	$10.1	$5.7
Unrestricted Cash	----	----	----	$31.5	$31.3	$34.7
Total Debt	----	----	----	$22.2	$20.4	$20.2
Capital Expenditures	----	----	----	$4.3	$2.0	$7.1
Profitability						
Operating Margin	2.1%	1.6%	2.3%	-5.8%	-2.5%	-3.5%
Operating EBIDA Margin	9.9%	8.1%	9.3%	-0.9%	1.8%	0.9%
Excess Margin	3.0%	1.6%	2.3%	-3.4%	0.2%	-1.5%
Debt Position						
Debt Service Coverage	3.2	2.4	3.0	0.9	3.3	2.6
Debt to Capitalization	36.6%	40.1%	43.1%	29.8%	29.3%	30.9%
Debt to Cash Flow	----	----	----	6.6	1.8	2.7
Liquidity						
Cash to Debt	117.4%	99.3%	88.2%	141.6%	153.1%	171.4%
Days Cash on Hand (days)	176.3	125.7	125.1	47.0	45.0	48.5
Days in A/R, net	47.4	45.5	45.1	55.4	46.6	45.6
Other						
Average Age of Plant	10.1	10.0	10.3	19.3	21.3	22.3
Compensation Ratio	50.9%	54.2%	49.0%	59.9%	55.6%	58.6%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	42.6%	20.7%	74.2%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

Greater Waterbury Health Network, Inc. and Subsidiaries Historical Credit Profile

($ in millions)	S&P[A]			Year ending September 30, Actual		
	A-	BBB+	BBB	2008	2009	2010
Net Patient Service Revenue	$248.2	$250.1	$177.0	$240.0	$258.1	$259.8
Operating Income	----	----	----	-$19.8	-$10.8	-$9.8
Operating EBIDA	----	----	----	-$7.6	$0.8	$1.9
Excess Income	----	----	----	-$14.7	-$3.8	-$3.9
Cash Flow (Net Inc + Depr)	----	----	----	-$4.2	$6.1	$6.0
Unrestricted Cash	----	----	----	$53.4	$53.1	$58.3
Total Debt	----	----	----	$27.8	$22.5	$21.8
Capital Expenditures	----	----	----	$4.3	$2.6	$5.6
Profitability						
Operating Margin	2.1%	1.6%	2.3%	-7.8%	-4.0%	-3.6%
Operating EBIDA Margin	9.9%	8.1%	9.3%	-3.0%	0.3%	0.7%
Excess Margin	3.0%	1.6%	2.3%	-5.7%	-1.4%	-1.4%
Debt Position						
Debt Service Coverage	3.2	2.4	3.0	(0.3)	1.0	2.5
Debt to Capitalization	36.6%	40.1%	43.1%	22.4%	23.4%	23.8%
Debt to Cash Flow	----	----	----	(11.1)	2.9	2.8
Liquidity						
Cash to Debt	117.4%	99.3%	88.2%	243.1%	250.5%	285.8%
Days Cash on Hand (days)	176.3	125.7	125.1	73.9	71.3	78.8
Days in A/R, net	47.4	45.5	45.1	56.1	46.7	45.8
Other						
Average Age of Plant	10.1	10.0	10.3	18.9	21.0	22.0
Compensation Ratio	50.9%	54.2%	49.0%	60.7%	56.2%	58.8%
Capital Spending Ratio [3]	156.9%	108.6%	112.6%	41.2%	25.9%	56.6%

Notes [A] Based on S&P's U.S. Not-For-Profit Health Care Stand-Alone 2009 Medians (published in 2010)

Financial Plan Assumptions

Capital Requirements ($ in thousands)

	2011	2012	2013	2014	2015	5-Year Total
Capital Uses						
P7 and OR renovations	$4,000					$4,000
Hospital capital	$4,150	$12,418	$13,727	$15,170	$16,768	$62,233
AMG capital	$245					$245
Cerner & IT capital	$5,113					$5,113
Cath lab replacement	$1,600					$1,600
	$15,108	$12,418	$13,727	$15,170	$16,768	$73,191
Strategic Investments						
CAW Practice	$4,900					
Phoenix Practice	$2,023					
Zlotoff Practice	TBD					
Wetmore Practice	TBD					
	$6,923					
Total All Capital	$22,031	$12,418	$13,727	$15,170	$16,768	$73,191
Capital Spending Ratio [A]	247.2%	120.0%	120.0%	120.0%	120.0%	139.8%

Note [A] S&P's "A-" and "BBB+" category medians for capital spending ratios are 157% and 107%, respectively.

Baseline Volume

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2010-2015 Total Growth
New Haven County Population	854,283	853,158	852,034	847,867	848,438	848,672	849,660	850,649	851,640	852,631	853,624	0.6%
Market Use Rates (per 1,000 pop)	119	121	120	120	120	120	120	120	120	120	120	
Total Market Volume	101,249	102,967	101,907	101,409	101,477	101,505	101,623	101,741	101,860	101,978	102,097	0.6%
Waterbury Mkt Share	10.3%	9.9%	10.1%	10.8%	10.2%	9.6%	9.6%	9.6%	9.6%	9.6%	9.6%	
Waterbury Inpatient Volume												
New Haven Volume	10,445	10,211	10,309	10,974	10,363	9,715	9,755	9,767	9,778	9,790	9,801	
Inmigration	3,531	3,550	3,534	3,763	3,553	3,331	3,345	3,348	3,352	3,356	3,360	
Total Admissions	**13,976**	**13,761**	**13,844**	**14,737**	**13,916**	**13,046**	**13,100**	**13,115**	**13,131**	**13,146**	**13,161**	0.9%
Annual growth		-1.5%	0.6%	6.5%	-5.6%	-6.3%	0.4%	0.1%	0.1%	0.1%	0.1%	

This results in an Average Daily Census of between 163 and 164 per year.

Outpatient visits were projected to increase 1% greater than inpatient volume, or 1.1% annually.

Revenue Assumptions

- The following net revenue increases per year have been assumed
  - Overall Charge Increase – 6.0%
  - Medicare Inpatient – (1.1%) in 2012, .55% in 2013, .3% in 2014, .4% in 2015
  - Medicare Outpatient – 1.8% in 2012, 1.85% in 2013, 1.6% in 2014, and 1.7% in 2015
  - Medicaid – Flat
  - Blue Cross – 4% annually (7% used in budget for FY 2011)
  - Commercial – . 4% annually (7% used in budget for FY 2011)
  - Managed Care - 4% annually (7% used in budget for FY 2011)
  - Self Pay – flat
  - VNA Services – 2% annually

- An investment earnings rate of 5.0% was assumed on all available cash.

Expense Assumptions

- Salaries were projected to increase 2.0% annually (1.5% in budget). FTE's were assumed to be 30% variable and 70% fixed with volume.
- Employee benefits were projected to remain at approximately 30% of salaries and wages over the projection period.
- Drugs were projected to increase 5% per year.
- Utilities were projected to increase 4% per year.
- Medical supplies were projected to increase 3.5% per year.
- Professional fees, purchased services, and other general expenses were projected to increase 3% per year.
- Insurance and other supplies were projected to increase 2% per year.
- Bad debt was projected to remain at about 1.9% of gross revenue over the projection period.

Baseline Productivity

	FTE's	FTE's per AOB	Compensation Ratio
2008	1,618.7	5.25	59.9%
2009	1,589.1	5.42	55.6%
2010	1,513.0	5.91	58.6%
2011	1,507.3	5.88	57.6%
2012	1,509.5	5.86	57.3%
2013	1,511.7	5.84	56.8%
2014	1,513.9	5.82	56.2%
2015	1,516.2	5.80	55.7%

DRAFT

Waterbury Hospital
Financial Analysis
December 2, 2010

Private and Confidential

PRICEWATERHOUSECOOPERS

Table of Contents

Section 1
Executive Summary

PRICEWATERHOUSECOOPERS

Executive Summary

PwC was engaged to evaluate the following:

- FY 2010 YTD Results vs. Budget
- FY 2011 Budget
- Hospital Run Rate
- Hospital Business Line Profitability / Marginal Profitability
- Initiatives Dashboards
- Leading Indicators Report

FY 2010 Actual to Budget

	FY2010 Actual	FY2010 Budget	Variance to Budget	% Variance to Budget
Net Revenue	$ 214,025,504	$ 228,549,429	$ (14,523,925)	-6.4%
Other Operating Revenue	9,734,335	7,915,625	1,818,710	23.0%
Total Operating Revenue	223,759,839	236,465,054	(12,705,215)	-5.4%
Total Expenses	229,237,303	227,774,129	1,463,174	0.6%
Income / (Loss) from Operations	(5,477,464)	8,690,925	(14,168,389)	163.0%
Non-Operating Income	1,916,451	1,392,700	523,751	37.6%
Net Income / (Loss)	$ (3,561,013)	$ 10,083,625	$ (13,644,638)	135.3%
Statistics:				
Admissions	13,046	13,786	(740)	-5.4%
Patient Days	59,271	69,378	(10,107)	-14.6%
ALOS	4.54	5.03	(0.49)	-9.7%
OR Procedures	3,272	3,550	(278)	-7.8%
One-Day Surgery Procedures	4,504	5,272	(768)	-14.6%
Observation Cases	1,072	785	287	36.6%
Outpatient Cases	168,418	175,211	(6,793)	-3.9%
Emergency Visits	49,031	46,302	2,729	5.9%
Overtime / Doubletime Dollars	$ 2,220,682	$ -	$ 2,220,682	n/a
Temporary Help Dollars	$ 838,767	$ 171,996	$ 666,771	387.7%
Payor Mix:				
Government	65.49%	64.83%	0.66%	
Non-Government (Excluding Self Pay)	32.51%	31.92%	0.59%	
Self Pay	2.00%	3.25%	-1.25%	

Overview of FY 2010 Financial Results

- Hospital has experienced a market share decline. FY 2010 admissions were 740 (5.4%) less than FY 2010 budget admissions
  - Orthopedic surgeons moved business to other hospitals
  - Physicians expressed frustration with newly rolled out IT processes and systems (enough to go to other hospitals)
  - Primary care physicians approached by other hospitals and ProHealth
- Actual patient days for FY 2010 were 10,107 less than the FY 2010 budget. 6,700 patient days of the budget variance are related to the FY 2010 reduction in length of stay (5.0 to 4.5); 3,300 patient days are related to reduced admissions
- FTEs per adjusted occupied bed increased from 5.17 to 6.05 (Budget vs. Actual FY2010). Staffing was not adjusted to reflect decrease in length of stay resulting from patient throughput initiatives
- $376K over budget on Accretion Expense due to previously unidentified asbestos
- Medicaid outpatient audit unfavorable impact of $1.1 million (management estimate)
- Fair Pay Workers' Compensation adjustment of receivables to 45% collectability, with an unfavorable impact of $1.8 million
- Employee benefits were over budget by $3.6 million, with $1.4 million attributable to behavioral health remaining within Waterbury Hospital instead of moving to Alliance Medical Group, $700K due to 30 FTE surplus over budget, and $700K due to post-audit adjustment to workers compensation
- Bad debt expense under budget by $8.1 million
- No adjustments were found in FY 2010 expenses

FY 2010 Actual Compared to FY 2011 Budget

The following is the FY 2010 Actual and FY 2011 Budget as stated by Waterbury Hospital:

	FY2010 Actual	FY2011 Budget
Net Revenue	$ 214,025,504	$ 225,999,921
Other Operating Revenue	9,734,335	9,549,161
Total Operating Revenue	223,759,839	235,549,082
Total Expenses	229,237,303	231,112,610
Net Income (Loss) from Operations	(5,477,464)	4,436,472
Non-Operating Income	1,916,451	1,605,000
Net Gain (Loss)	$ (3,561,013)	$ 6,041,472

FY 2011 Budget Overview

The following is a summary of Waterbury Hospital's FY 2011 Budget:

- Gain from operations of $4.4 million, net gain of $6.0 million
- Refinancing that increases cash by approximately $13.4 million ($8.0 million in additional borrowings, $3.4 million reduction to 55 days cash on hand requirement and $2.0 million debt service reserve fund no longer required)
- Additions to property, plant, and equipment of $15.1 million, which includes $5.1 million in Cerner and IT capital spend, $4.0 million for Pomeroy 7 and Operating Room renovations, $1.6 million for Cath Lab replacement, and $4.4 million for routine hospital capital
- Strategic investment in CAW of $2.4 million (acquisition) and $2.5 million of working capital and Electronic Medical Records costs
- Other strategic investments in Phoenix, and other practices
- Average age of plant of 25 years for the Hospital at the end of FY 2011
- Days cash on hand at 9/30/11 is 55 days
- FTEs per adjusted occupied bed increasing from FY 2009 actual level of 5.41 to 6.05 for budgeted FY 2011

FY 2011 Significant Findings

- Proposed adjustments that would reduce net revenue by $12.5 million (these adjustments have not been reviewed with management)
- Reduction in net revenue significantly impacts cash and the hospital's ability to pay for capital expenditures and will impact bond covenants
- Preliminary 5 year capital plan (not completed, where plan stood as of 11/30/10) has approximately $88.6 million of capital needs identified. Significant operating margins will be needed to meet future capital needs. Operating margins will need to be between 4% and 5% annually for the next 5 years to achieve the $88 million of capital needs
- Replacement time is not consistently budgeted across all departments and no position control system has been maintained, this will yield unexpected variances in temporary help and overtime
- To reach 50th percentile benchmark levels, FTEs per adjusted occupied bed would need to be reduced by approximately 236 with an associated reduction in salaries and benefits of approximately $20.4 million. Approximately 25-30 of these FTEs currently exist in inpatient nursing

Summary of Potential Adjustments to FY 2011 Budget

Net Revenue	Proposed Adjustment to Budget	Potential Volume Exposure	Total
Medicare Case Mix Index			
Acute Renal Failure Coding Change	$ (1,403,000)		$ (1,403,000)
FY 2010 Case Mix - (1.715 to 1.6956)	(723,000)		(723,000)
Decline in Surgical Cases*		$ (5,624,000)	(5,624,000)
Observation Cases (Medicare)	(595,000)		(595,000)
Fair Pay - Overstatement of Charges	295,000		295,000
Fair Pay - Adjustment to Current Payment Rates from Potential Contract Rates	(350,000)		(350,000)
Outpatient Payment Factors	(1,520,000)		(1,520,000)
Medicaid Outpatient Audit Exposure	(733,000)		(733,000)
RAC Audit Exposure (FY 2011)	(1,040,000)		(1,040,000)
Medicare Physician Payment Reduction (23% Jan - Sept)[1]	(125,000)		(125,000)
Commercial Insurance Adjustment (No Support)	255,000		255,000
Medicare Inpatient Prospective Payment System Final Rule	(273,000)		(273,000)
Length of Stay and Payor Mix	(700,000)		(700,000)
TOTAL Net Revenue Adjustment	**$ (6,912,000)**	**$ (5,624,000)**	**$ (12,536,000)**

** Estimated to be a decline of 360 orthopedic discharges based upon the latest volume trends. This translates to a potential exposure of approximately $5,624,000 (360 cases x net revenue of $15,622 per orthopedic surgical case) assuming this trend continues.*

[1] Reduced reimbursement unlikely to occur.

FY 2010 Actual Compared to FY 2011 Budget

The following is a summary of the proposed adjustments to the fiscal year 2011 budget:

	FY2010 Actual	FY2011 Budget	Proposed Adjustments	Adjusted FY2011 Budget
Net Revenue	$ 214,025,504	$ 225,999,921	$ (12,536,000)	$ 213,463,921
Other Operating Revenue	9,734,335	9,549,161	-	9,549,161
Total Operating Revenue	223,759,839	235,549,082	(12,536,000)	223,013,082
Total Expenses	229,237,303	231,112,610	-	231,112,610
Net Income (Loss) from Operations	(5,477,464)	4,436,472	(12,536,000)	(8,099,528)
Non-Operating Income	1,916,451	1,605,000	-	1,605,000
Net Gain (Loss)	$ (3,561,013)	$ 6,041,472	$ (12,536,000)	$ (6,494,528)

FY 2011 - October Actual to Budget

The following is a summary of the October 2010 actual to budget:

	Oct 2010 Actual	Oct 2010 Budget	Variance to Budget	% Variance to Budget
Net Revenue	$ 17,799,080	$ 18,087,868	$ (288,788)	-1.6%
Other Operating Revenue	682,013	795,767	(113,754)	-14.3%
Total Operating Revenue	18,481,093	18,883,635	(402,542)	-2.1%
Total Expenses	18,914,767	19,846,983	(932,216)	-4.7%
Income / (Loss) from Operations	(433,674)	(963,348)	529,674	55.0%
Non-Operating Income	101,733	113,750	(12,017)	-10.6%
Net Income / (Loss)	$ (331,941)	$ (849,598)	$ 517,657	60.9%
Statistics:				
Admissions	1,047	1,048	(1)	-0.1%
Patient Days	4,672	4,750	(78)	-1.6%
ALOS	4.46	4.53	(0.07)	-1.5%
Medicare CMI	1.66	1.71	(0.05)	-2.9%
OR Procedures	226	263	(37)	-14.1%
One-Day Surgery Procedures	354	367	(13)	-3.5%
Outpatient Cases	14,062	13,435	627	4.7%
Emergency Visits	4,045	3,986	59	1.5%
Payor Mix:				
Medicare	36.0%	40.3%	-4.3%	
Managed Medicare	8.9%	7.2%	1.7%	
Medicaid	11.0%	10.0%	1.0%	
Managed Medicaid	7.8%	7.3%	0.6%	
Commercial	9.7%	11.0%	-1.3%	
Managed Care	23.5%	22.1%	1.3%	
Self Pay	3.1%	2.0%	1.0%	

Action Steps

The following are recommended priority action steps:

- Prepare and execute on action plans to mitigate market share declines
- Realign staffing and other costs to match latest length of stay and discharge volume trends
- Implement monthly financial reporting, budgeting and decision support systems; establishing accountability and alignment with a metrics driven organization
- Compile and implement a financial plan that addresses the following:
    - Days cash on hand
    - Average age of plant /other capital needs
    - Income from operations to achieve above
- Execute Cerner upgrades and module implementation
- Plan for health care reform (reductions in government payments will require hospitals to reduce operating expenses by 3-5% per year for the foreseeable future)
- Explore capital partner/affiliation/merger strategy

Section 2
FY 2010 YTD Results vs. Budget

PRICEWATERHOUSECOOPERS

FY 2010 Actual to Budget

	FY2010 Actual	FY2010 Budget	Variance to Budget	% Variance to Budget
Net Revenue	$ 214,025,504	$ 228,549,429	$ (14,523,925)	-6.4%
Other Operating Revenue	9,734,335	7,915,625	1,818,710	23.0%
Total Operating Revenue	223,759,839	236,465,054	(12,705,215)	-5.4%
Total Expenses	229,237,303	227,774,129	1,463,174	0.6%
Income / (Loss) from Operations	(5,477,464)	8,690,925	(14,168,389)	163.0%
Non-Operating Income	1,916,451	1,392,700	523,751	37.6%
Net Income / (Loss)	$ (3,561,013)	$ 10,083,625	$ (13,644,638)	135.3%
Statistics:				
Admissions	13,046	13,786	(740)	-5.4%
Patient Days	59,271	69,378	(10,107)	-14.6%
ALOS	4.54	5.03	(0.49)	-9.7%
OR Procedures	3,272	3,550	(278)	-7.8%
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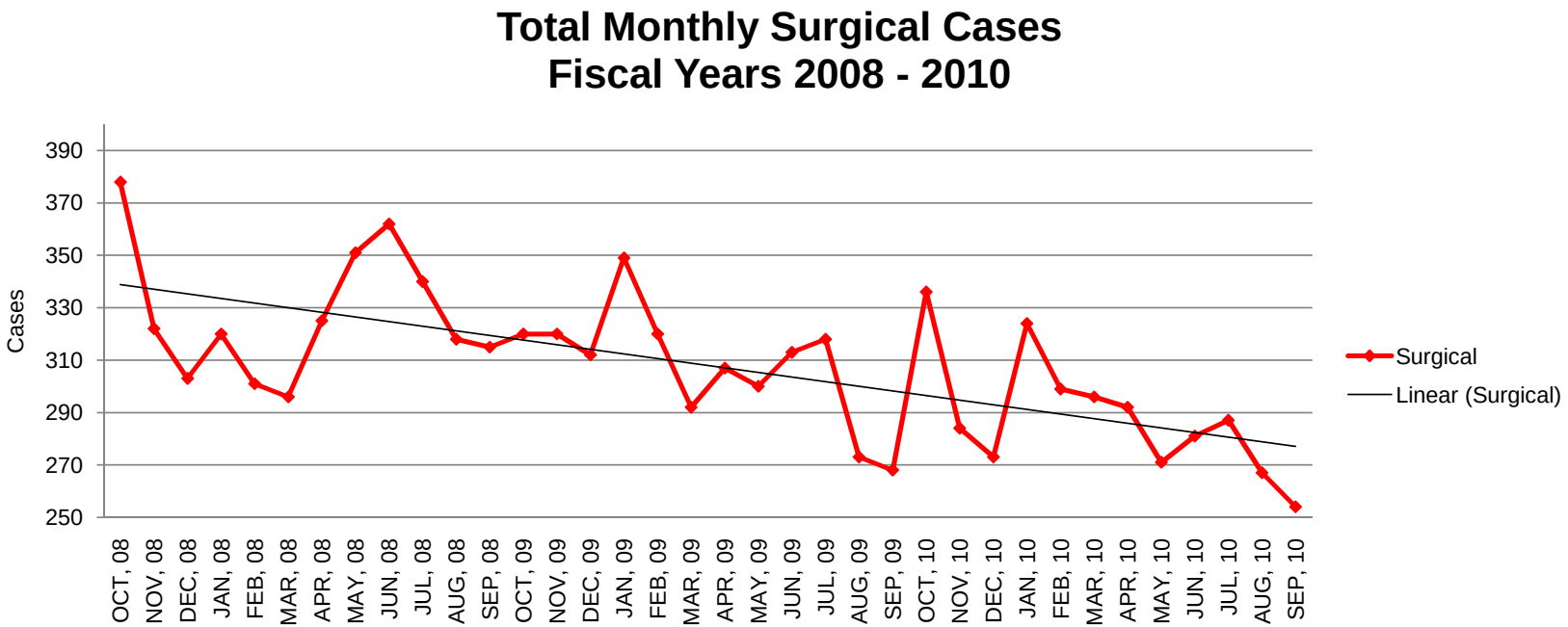
Emergency Visits	49,031	46,302	2,729	5.9%
Overtime / Doubletime Dollars	$ 2,220,682	$ -	$ 2,220,682	n/a
Temporary Help Dollars	$ 838,767	$ 171,996	$ 666,771	387.7%
Payor Mix:				
Government	65.49%	64.83%	0.66%	
Non-Government (Excluding Self Pay)	32.51%	31.92%	0.59%	
Self Pay	2.00%	3.25%	-1.25%	

Volume – Anecdotal Findings

- Inpatient discharge volume for the State of Connecticut is basically flat for FY 2010 when compared to FY 2009 (through June 30)
- Primary care physicians have been recruited/approached by other hospitals and ProHealth
- Orthopedic surgeons have moved surgical volume to other hospitals
- Some physicians have expressed frustrations with newly rolled out IT processes and systems
  - "Depart" process
  - Medication reconciliation
  - Performance improvement initiatives in perioperative services and throughout the hospital

Total Surgical Cases



Budgeted Expense Evaluation

The following actions were taken when reviewing the budgeted expenses:

- Determined the cause of the budget to actual 30 FTE variance for FY2010 and the impact of temporary help and overtime on payroll expense by cost center
- Evaluated budget to actual variances by cost center for FY2010 and corresponding actual FY2009 values and budgeted FY2011 values. All positive or negative variances over 10% were evaluated in detail to identify cause(s) of discrepancy
  - Interviewed Senior Budget Analyst to discuss discrepancies and understand cause of high dollar and/or variance expense items
- Interviewed Executive Director of Process Improvement to understand use of dashboards and progress on key cost reduction initiatives
- Evaluated yearly Cerner implementation operational and capital expenses
- Gained insight on FY2011 $2M projected medical/surgical supply expense reduction and GPO expense reductions realized in FY2010

Expense Indicator Evaluation

Patient throughput initiatives are successful. Further FTE reductions were not reflective of decreased demand.

Indicator	FY2009 Actual	FY2010 Budget	FY2010 Actual	FY2011 Budget	Trend
Patient Days	67,682	69,378	59,271	59,378	↓
Admissions	13,928	13,786	13,046	13,100	↓
Overall Case Mix Index (CMI)	1.35	1.35	1.39	1.39	↑
Average Length of Stay (ALoS)	4.86	5.03	4.54	4.53	↓
FTEs	1,589	1,482	1,513	1,507	↓
Total Salary Spend	105,995,288	101,436,095	98,725,135	100,143,265	!
FTEs per Adjusted Occupied Bed	5.41*	5.17	5.91	6.05	↑

* Median FTEs per adjusted occupied bed for the state of Connecticut was 4.60 (FY2009). Waterbury Hospital ranked 24th out of 30 Connecticut hospitals. Solucient Action OI adjusted occupied bed 50th percentile benchmark is 5.10

Expense Review

46 cost centers ran over budget for FTEs during FY2010:

- A total of 40 FTEs were used above budget
- 11 FTEs (28%) are attributed to unbudgeted performance improvement initiatives
- 18 FTEs (45%) are in four Nursing Units experiencing reductions in patient days
  - One of these units also had in excess of $200K in Temporary Help
  - An analysis of September 2010 performance shows these trends continuing
- The remainder are in small increments across many cost centers

Budget to Actual Expense Variances

The following represents a sample of the causes for the budget to actual variances during FY 2010:

- *Clinical Resource and Quality Management:* $365K variance due to DPH findings
- *Employee Benefits:* $1.38M budgeted benefit reduction not realized by hospital due to behavioral health not transferring to Alliance Medical Group
- *Administrative Finance:* unbudgeted $962K a result of ED Medicaid billing for AMG
- *Ultrasound & Diagnostic Radiology:* $185K over budget for clinical engineering repairs
- *Special Procedures:* $189K over budget for Patient Chargeable Supplies despite volume decrease
- *Chase Clinic:* $211K unbudgeted line item result of expense sharing with AMG
- *Interest Expense:* $376K over budget on Accretion Expense due to previously unidentified asbestos

Significant Year End Adjustments

Waterbury Hospital experienced a slight gain from operations through June 2010. However, the final three months of the year resulted in an approximate $5.7 million loss from operations, resulting in a year-end loss from operations of $5.5 million.

The following represents significant adjustments to the final three months of FY2010:

- $5.9 million decrease in the average net revenue when compared to the previous nine months:
  - Favorable FY 2010 Medicaid cost report settlement of $1.8 million
  - Net revenue decrease of approximately $6.1 million primarily a result of decline in volume
  - Fair Pay Workers' Compensation adjustment of receivables to 45% collectability, with an unfavorable impact of $1.8 million
  - Medicaid outpatient audit unfavorable impact of $1.1 million (management estimate)
  - Bad debt / free care / UCP decrease of $1.3 million

Significant Year End Adjustments (continued)

The following represents significant adjustments to the final three months of FY2010 (continued):

- $295 thousand increase in average expenses when compared to the previous nine months:
  - Workers' Compensation actuarial favorable adjustment of $700 thousand to expense
  - Operations improvement expense decrease of approximately $870 thousand
  - Medical and surgical supplies expense decrease of approximately $855 thousand
  - $380K over budget on Accretion Expense due to previously unidentified asbestos
  - Purchased services expense increase of approximately $1.4 million
  - Alliance Medical Group expense increase of approximately $870 thousand
  - Other expense increases of approximately $70 thousand
- $470 thousand increase in average other operating revenue when compared to the previous nine months

Section 3
FY 2011 Budget

PRICEWATERHOUSECOOPERS

Significant Budget Assumptions

- Refinancing – generates approximately $13.4 million in cash
- Volume assumptions:
  - Discharges increased from 13,046 (FY 2010 Actual) to 13,100 for FY 2011 budget
  - Average Length of Stay held constant at FY 2010 actual of 4.5 days
  - Outpatient cases decreased from 168,418 to 167,936, a decrease of 0.29%
- No change to Medicare case mix from FY 2010 Actual (through June)
- Medical/Surgical supply expense savings initiative related to utilization and state contracts ($2,095,000 in savings)
- Payer mix assumes no changes in FY 2011 from FY 2010 actual
- Cerner 10% contingency fee worth approximately $511K not reflected in FY2011 budgeted capital uses

Volume Roll Forward

	Budget 2011	Comments
Projected 2010 I/P Cases	**13,007**	**Based on 10/09-8/10 Actual (11,936) plus 9/10 Projected (1,071)**
Adjustments:		
Angioplasty	11	Annualized YTD June 2010
Gynecology-Surgical	13	Increased to FY09 levels
Major Joint	5	Annualized YTD June 2010
Maternity	-	Annualized YTD Feb 2010 plus 14 Charter Oak cases
Medical	136	Annualized YTD Feb 2010 plus 50 cases (per Kelvin) & 200 Observation cases
Medical Cardiology	(30)	Annualized YTD Feb 2010
Mental Disease / Substance Abuse	(7)	Annualized YTD Feb 2010 plus 9%
Neurosurgery	(12)	Annualized YTD Feb 2010 less 17 cases (per EMT)
Newborn	(3)	Annualized YTD Feb 2010 less 2% plus 14 Charter Oak cases
Ortho	(41)	Annualized YTD Feb 2010
Ortho - Nonsurgical	(7)	Annualized YTD Feb 2010
Surgical	4	240 per quarter (per EMT), plus 10 new cases (per Kelvin)
Surgical Cardiology	37	Annualized YTD Feb 2010, plus 10 new open heart plus 21 new pacemakers
Urology	(13)	Annualized YTD Feb 2010, decreased as a result of DaVinci robot at St. Mary's
Total Adjustments	**93**	
Total Cases - Budget 2011	**13,100**	

Summary of Potential Adjustments

Net Revenue	Proposed Adjustment to Budget	Potential Volume Exposure	Total
Medicare Case Mix Index			
Acute Renal Failure Coding Change	$ (1,403,000)		$ (1,403,000)
FY 2010 Case Mix - (1.715 to 1.6956)	(723,000)		(723,000)
Decline in Surgical Cases*		$ (5,624,000)	(5,624,000)
Observation Cases (Medicare)	(595,000)		(595,000)
Fair Pay - Overstatement of Charges	295,000		295,000
Fair Pay - Adjustment to Current Payment Rates from Potential Contract Rates	(350,000)		(350,000)
Outpatient Payment Factors	(1,520,000)		(1,520,000)
Medicaid Outpatient Audit Exposure	(733,000)		(733,000)
RAC Audit Exposure (FY 2011)	(1,040,000)		(1,040,000)
Medicare Physician Payment Reduction (23% Jan - Sept)[1]	(125,000)		(125,000)
Commercial Insurance Adjustment (No Support)	255,000		255,000
Medicare Inpatient Prospective Payment System Final Rule	(273,000)		(273,000)
Length of Stay and Payor Mix	(700,000)		(700,000)
TOTAL Net Revenue Adjustment	**$ (6,912,000)**	**$ (5,624,000)**	**$ (12,536,000)**

** Estimated to be a decline of 360 orthopedic discharges based upon the latest volume trends. This translates to a potential exposure of approximately $5,624,000 (360 cases x net revenue of $15,622 per orthopedic surgical case) assuming this trend continues.*

[1] Reduced reimbursement unlikely to occur.

Summary of Potential Adjustments (continued)

- **Acute Renal Failure Coding Change**
  - Regulatory change (statutory on 10/1/10) where acute renal failure is no longer a Major Complication and Comorbidity (MCC) and is now a Complication and Comorbidity (CC). Hospital had 343 Medicare cases where acute renal failure was the only MCC. We adjusted to the CC payment factor for 75% of the cases
- **FY 2010 Case Mix**
  - Reduction in case mix from budgeted 1.715 to actual FY 2010 of 1.6956
- **Decline in Surgical Cases**
  - Exposure due to orthopedic surgeons moving surgical volume to other hospitals and decline in surgical volume in second half of FY 2010 and decline in October 2010
- **Observation Cases (Medicare)**
  - Reduction in case mix from overall Medicare (budget FY 2011) 1.715 to .7908 (actual Medicare case mix for observation cases) for 85 Medicare observation cases that management has assumed will convert to inpatient
- **Fair Pay – Overstatement of Charges**
  - Budget assumed $2.5 million in Fair Pay charges. Actual FY 2010 charges were approximately $1.5 million. Therefore, Fair Pay impact was overstated in FY 2011 budget
- **Fair Pay – Adjustment to Current Payment Rates from Potential Contract Rates**
  - Reduction in Fair Pay payment factor from 47% to 25%. Budget assumes Fair Pay contract (that is assumed to pay 45% of charges) will be entered into for FY 2011. Through November 2010, no contract signed and no contract discussions occurring

Summary of Potential Adjustments (continued)

- **Outpatient Payment Factors**
  - Six percent charge increase not factored into Payment on Account Factor (PAF), thus overstating net revenue. Overstatement minimized by a 4% update factor used rather than the managed care and commercial update factor of 9% and 6%
- **Medicaid Outpatient Audit (FY 2011)**
  - Calculated as management's reserve estimate of $1.1 million for the 18 months ending 9/30/09. Applied to FY 2011. External auditors indicated there is enough general reserve at 9/30/10 to cover FY 2010 exposure
- **RAC Audit Exposure (FY 2011)**
  - Management indicated there was $40,000 and $240,000 of exposure for the first two record reviews by RAC. Record requests for review can be made every 45 days. Exposure calculated at average exposure to-date ($140,000) applied to eight potential reviews per year for FY 2011
- **Medicare Physician Payment Reduction (23%)**
  - Total budgeted Medicare physician payments of approximately $725,000 were reduced by 23% for nine months of FY 2011 (Congress passed one-month fix to the Medicare payment formula, not likely to occur)
- **Commercial Insurance Adjustment (No Support)**
  - Exposure due to lack of support for inpatient commercial insurance rate decrease

Summary of Potential Adjustments (continued)

- **Medicare Inpatient Prospective Payment System Final Rule**
  - Represents using the final Medicare Inpatient Prospective Payment rate for FY 2011 vs. the proposed rule for the budget
- **Length of Stay and Payor Mix**
  - Utilized the final, actual FY 2010 length of stay and payor mix for net revenue calculations

Review of 2011 Monthly Budget Spread Observations

- Total budgeted admissions spread to each month based on non-holiday / non-weekend days per month, as adjusted for the following:
  - Management's estimate of seasonality
  - Additional 200 observation admissions, the impact of which will not begin to be realized until January 2011
  - Approximately 160 discharges were moved out of first quarter of budgeted FY 2011 to the last nine months of FY 2011 to account for seasonality and ramp up of additional observation admissions
- The following were the monthly expense allocation methodologies employed by Management for each expense category:
  - Gross charges / contractual allowances / bad debt / free care / UCP: based on allocated admissions (see above)
  - OOR / NOR: allocated evenly to each month
  - Salary: based on total days in each month
  - Benefits: based on pay dates in each month
  - Professional legal: allocated evenly to each month

Cerner Implementation Capital Expenses

- Projected Cerner and IT capital expenses for FY2010 – FY2016 total over $19M
- Cerner incremental operating expense for FY2011 budgeted at $2.3M
- Cerner project cost for FTEs is estimated at an ongoing impact of $525,232, which is not reflected in the Cerner budgeted operating expenses

	FY10	FY11	FY12	FY13	FY14	FY15	FY16	TOTAL
Cerner Contract-Related Capital Costs								
License Software		$ 330,286	$ 90,194	$ 90,194	$ 90,194	$ 90,194	$ 90,194	$ 781,258
Implementation / Services		520,364	323,500	548,417	323,500	520,364	302,453	2,538,598
Hardware Costs	$ 423,489	300,000	160,894					884,383
Total Cerner Only Capital Costs & Hardware	**423,489**	**1,150,650**	**574,588**	**638,611**	**413,694**	**610,558**	**392,647**	**4,204,239**
Non-Cerner Fees - Capital								
Consulting Fees	1,000,000	2,000,000	1,000,000					4,000,000
Internal Capital Budgeted Updgrades	986,000	1,500,000	1,500,000	1,572,000	1,217,000	1,085,000	1,070,000	8,930,000
Cerner Travel to WH	31,350	198,725	90,000					320,075
3rd Party Travel to WH	48,000	264,000	288,000					600,000
Total Costs (Capital)	**2,488,839**	**5,113,375**	**3,452,588**	**2,210,611**	**1,630,694**	**1,695,558**	**1,462,647**	**18,054,314**
Contingency - 10%	**248,884**	**511,338**	**345,259**					**1,105,480**
Out of Scope Total (Contingency Used)	**25,000**	-	-	-	-	-	-	**25,000**
Annual Totals	**$ 2,762,723**	**$ 5,624,713**	**$ 3,797,847**	**$ 2,210,611**	**$ 1,630,694**	**$ 1,695,558**	**$ 1,462,647**	**$ 19,184,794**

* Provided by Waterbury Hospital

Budget Recommendations

- Implement an integrated budgeting system and process
  - Existing database is homegrown
  - Current process is heavily reliant on Excel spreadsheets
  - Standardize annual and monthly budget “packages”
- Adopt consistent budget methodology
  - Modeling should segregate inputs, calculations, and review sheets
  - Improve work paper documentation
  - Presentation of significant detailed assumptions should be improved
  - Gross and net revenue assumptions not well documented
- Coordination of budget process needs to be improved
- Adopt consistent budget review process
- Create and document policies and procedures
- Consider documenting exposure items and threats

Budget Recommendations (continued)

- Improve discipline around budget to actual process to ensure alignment of budget and actual line items expenses by cost center to improve transparency of budgeting discrepancies
- Set consistent expectations for accountability and monthly feedback on any budget to actual variances by cost center
- Improve controls around revenue and expense sharing with Alliance Medical Group
- Clinical engineering repair budget needs to take into consideration increasing age of plant and equipment
- Reinstate position control process
- Each department should budget replacement time with applicable overtime and temporary help allocations
- Realign staffing to reflect the 0.5 day drop in LOS achieved through patient throughput initiatives

Budget Recommendations (continued)

- Recommendations for monthly budget allocations:
  - To begin, the monthly spread of the FY 2011 budget is an improvement over the prior year, where everything was allocated evenly to each month, as adjusted for monthly initiatives
  - Going forward, best practice is to incorporate actual historical volume and expense trends into the monthly revenue and expense allocations (where appropriate)
  - Interest expense should be allocated to each month based on actual amortization schedules
  - Depreciation expense allocations should incorporate when assets are anticipated to come on-line during the year
  - Work paper documentation of the monthly budget spread process, including all assumptions, should be improved

Section 4
Hospital Run Rate

PRICEWATERHOUSECOOPERS

Meeting with External Auditors

We met with Chris Jackson, Partner, Marcum, LLP, on November 23. The following is a summary of our discussion:

- The audit is progressing and the auditors are planning on field work to be completed week of November 29
- The Hospital is in the process of updating the financial statements for all known adjustments
- All known audit adjustments are recorded by the Hospital for FYs 2008 through 2010. The look-back procedures for accounts receivable have not resulted in any significant adjustments
- General reserves appear to be adequate to cover all know exposures through September 30, 2010 and include the following:
  - Recover Auditor Contractor (RAC)
  - Outpatient Medicaid
  - Fair Pay Workers Compensation accounts receivable valuation (assume collection at 45% of charges – see following slides)

Fair Pay Workers Compensation

- Management has represented that they will collect up to 45% of gross charges for Fair Pay Workers Compensation accounts receivable:
  - Total Fair Pay accounts receivable has a balance of $2,861,000 on accounts for the period FY 2006 through FY 2010
  - Total reserves for the Fair Pay accounts receivable is approximately $1,854,000, leaving a net value of $1,007,000 at September 30, 2010
  - Hospital has currently been paid $1,330,000 on these accounts which represents a collection percentage of 25.6%
  - Hospital has hired an outside agency and an outside attorney to assist with obtaining a contract going forward and a settlement of prior open accounts receivable balances

Fair Pay Workers Compensation (continued)

- The following summarizes the potential exposure to Waterbury Hospital if no further monies are received related to Fair Pay Workers Compensation claims for FY2006-FY2010:

A	*B*	*C*	*D*	*E*	*F*
					EXPOSURE
Fiscal Year	Gross Revenue	Management-Assumed Net Revenue at 45% of Charges *(B x 45%)*	Collections To-Date	Collection % To-Date *(D ÷ B)*	Management-Assumed Left to Collect at 45% *(C - D)*
FY2006	$ 166,747	$ 75,036	$ 40,940	24.55%	$ 34,096
FY2007	952,771	428,747	250,844	26.33%	177,903
FY2008	1,301,048	585,472	355,565	27.33%	229,907
FY2009	1,324,549	596,047	333,898	25.21%	262,149
FY2010	1,447,547	651,396	348,890	24.10%	302,506
Total	**$ 5,192,662**	**$ 2,336,698**	**$ 1,330,137**	**25.62%**	**$ 1,006,561**

Adjustments That Are Related to Prior Years

	Prior Years	2008	2009	2010
(Loss) From Operations per Audited Financial Statements		$ (12,360,105)	$ (4,986,257)	$ (7,756,250)
Fiscal Year 2010 Third Party Reserve Adjustments, Settlements, and Appeals	$ 837,221	86,865	(281,020)	(643,066)
Fiscal Year 2010 Adjustments to Expenses	0	0	0	0
	837,221	86,865	(281,020)	(643,066)
Fiscal Year 2009 Third Party Reserve Adjustments, Settlements, and Appeals	534,614	526,300	(1,060,914)	0
Fiscal Year 2009 Adjustments to Expenses	0	0	0	0
	534,614	526,300	(1,060,914)	0
Fiscal Year 2008 Third Party Reserve Adjustments, Settlements, and Appeals	1,932,004	(1,932,004)	0	0
Fiscal Year 2008 Adjustments to Expenses	0	0	0	0
	1,932,004	(1,932,004)	0	0
Total FY 2010, 2009, 2008 Adjustments	**3,303,839**	**(1,318,839)**	**(1,341,934)**	**(643,066)**
Adjusted (Loss) From Operations	**$ 3,303,839**	**$ (13,678,944)**	**$ (6,328,191)**	**$ (8,399,316)**
Medicare Section 508 Wage Index Incremental Net Revenue		**$ 697,000**	**$ 1,477,000**	**$ 1,358,000**

Prior Year Adjustments - Detail

Adjustment Number	Adjustment Description	Actual			
		Prior Years	2008	2009	2010
	(Loss) From Operations per Audited Financial Statements		$ (12,360,105)	$ (4,986,257)	$ (7,756,250)
	Fiscal Year 2010 Adjustments				
1	FY 2003 Medicare Bad Debt and DSH Reopening	$ 617,221			(617,221)
2	FY 2004-2006 Medicare Bad Debt Reopening	220,000			(220,000)
3	FY 2008 Medicare Audit Adjustments		453,532		(453,532)
4	FY 2009 As Filed Medicare Cost Report			452,313	(452,313)
5	FY 2010 Medicaid Cost Report				TBD
6	Fair Pay Adjustments to Accounts Receivable				TBD
7	Medicaid Outpatient Audit Additions		(366,667)	(733,333)	1,100,000
	Fiscal Year 2010 Adjustment Subtotal	837,221	86,865	(281,020)	(643,066)
	Fiscal Year 2009 Adjustments				
1	FY 1997 Medicare DSH Appeal	720,222		(720,222)	
2	FY 2000 Medicare DSH Appeal	80,250		(80,250)	
3	FY 2001 Medicare DSH Appeal	234,595		(234,595)	
4	FY 2002 Medicare DSH Appeal	131,780		(131,780)	
5	FY 2002 Reopening Cross Over Bad Debts	40,027		(40,027)	
6	FY 2007 Medicare Audit Adjustments Summary Exit Conference	(171,185)		171,185	
7	FY 2007 MedicareTricare/Champus 2007 Initial Cost Report Settlement	19,872		(19,872)	
8	FY 2008 Medicare Miscellaneous		5,441	(5,441)	
9	FY 2007 Medicaid Cost Report	(538,558)		538,558	
10	FY 2007 Medicaid Cost Report	17,611		(17,611)	
11	FY 2008 Medicaid Outpatient Audit		520,859	(520,859)	
	Fiscal Year 2009 Adjustment Subtotal	534,614	526,300	(1,060,914)	
	Fiscal Year 2008 Adjustments				
1	FY 1992-1994 Appeal-Baystate	(84,440)	84,440		
2	Reopening Settlement Net of DSH	460,984	(460,984)		
3	FY 2005 Medicare As Filed Cost Report	(231,659)	231,659		
4	FY 2005 Medicare Initial Settlement	73,000	(73,000)		
5	FY 2005 Medicare Revised After FY 2004 audit and 2005 overlap	149,117	(149,117)		
6	FY 2005 Medicare Final Settlement	279,584	(279,584)		
7	FY 2006 Medicare Revised after FY 2004 Audit	141,934	(141,934)		
8	FY 2007 Medicare Initial Settlement	444,640	(444,640)		
9	FY 2005 Medicaid Outpatient Audit	110,077	(110,077)		
10	FY 2005 Medicaid As-filed Cost Report	(324,183)	324,183		
11	FY 2006 Medicaid As-filed Cost Report	37,081	(37,081)		
12	FY 2006 Medicaid Outpatient Audit	23,073	(23,073)		
13	FY 2007 Medicaid Misc.	9,238	(9,238)		
14	FY 2007 Medicaid Cost Report Not Yet Filed	538,558	(538,558)		
15	FY 2008 Reserve Adjustment	305,000	(305,000)		
	Fiscal Year 2008 Adjustment Subtotal	1,932,004	(1,932,004)		
	Total FY 2010, 2009, 2008 Adjustments	**3,303,839**	**(1,318,839)**	**(1,341,934)**	**(643,066)**
	Adjusted (Loss) From Operations	**$ 3,303,839**	**$ (13,678,944)**	**$ (6,328,191)**	**$ (8,399,316)**

*Per Consolidating Statement of Operations
Waterbury Hospital Only

Section 5
Decision Support and Marginal Profitability

PRICEWATERHOUSECOOPERS

Decision Support Observations

- Trendstar Decision Support system has been in place since 1993
  - DOS-based
  - System performance issues
- All costs spread using ratio of cost to charges
- Difference between internal financial statement net revenue and net revenue per Trendstar is spread based on percent of total gross charges
  - No time and motion studies used
  - No RVUs used
- Decision support output is directional. More in-depth analysis needs to be performed before action is taken

Product Line Recommendations

- **General**
  - Indirect fixed costs in FY 2010 are 38%of total costs. Reducing this percentage to a benchmark of 35% would save approximately $6.9 million
  - Each product line should have a detailed business plan that considers volume trends, reimbursement, and steps to improve operational efficiencies
  - Document key inputs and assumptions to the models for consistency on a roll forward basis
- **Psychology**
  - Approximately 42% of psychology volume is driven by Medicaid
  - Certificate of Need approval is required by the Office of Health Care Access in order to discontinue psychology services
  - Business plan should include lobbying for increased Medicaid rates
  - All grant funded programs should fully cover the salary and expenses, with evaluation of this each year to determine continuation
- **Cardiology**
  - The CVU transitional care model is a more expensive model of care
  - National trends show a decrease in open heart surgeries
  - The CAW physician alignment strategy should improve volume

Product Line Recommendations

- **Observation**
  - Increase in observation days/admissions corresponds to better patient identification by case management
  - Management has recently contracted with Accretive Health to address documentation gaps with observation status patients and those who convert to inpatient
  - Observation units rarely stand on their own bottom financially – rather they provide open bed capacity for higher contribution inpatient cases
- **Offsite Outpatient Services**
  - Determine business plan for offsite services including volume requirements to continue business
  - Evaluate frequency of services and actual modalities available. Interview physician users of offsite locations to understand their practice and referral patterns

Fiscal Year 2010 Profitability by Product Line - Direct Margin*

Fiscal Year 2010 Profitability by Product Line* (in thousands)

	Needs Improvement → Performing														
	EEG	GI	Psych	Observation	Sleep Lab	Outpatient Labs	Offsite Outpatient Services	Women & Infants	Radiology	ER	Cardiology	Orthopedics	All Other Surgery	IP - Medical	Total
Gross Charges	$ 1,828	$ 5,142	$ 53,751	$ 20,360	$ 9,196	$ 22,717	$ 28,260	$ 33,102	$ 28,876	$ 83,215	$ 116,904	$ 91,614	$ 164,121	$ 158,240	$ 817,326
Contractual Allowances (Inferred)	(1,285)	(3,316)	(40,078)	(16,353)	(6,950)	(18,364)	(21,646)	(21,335)	(23,173)	(63,059)	(87,133)	(61,969)	(119,811)	(109,567)	(594,039)
Net Revenue	543	1,826	13,673	4,007	2,246	4,353	6,614	11,767	5,703	20,156	29,771	29,645	44,310	48,673	223,287
Direct Department Cost	(215)	(1,109)	(10,370)	(2,793)	(1,004)	(2,830)	(4,444)	(8,382)	(2,071)	(9,523)	(18,000)	(17,678)	(22,129)	(22,800)	(123,348)
Direct Department Beneifts	(11)	(201)	(2,697)	(474)	(155)	(361)	(482)	(1,476)	(269)	(1,888)	(2,340)	(1,368)	(3,218)	(4,504)	(19,444)
Direct Contribution Margin	$ 317	$ 516	$ 606	$ 740	$ 1,087	$ 1,162	$ 1,688	$ 1,909	$ 3,363	$ 8,745	$ 9,431	$ 10,599	$ 18,963	$ 21,369	$ 80,495
Direct Contribution Margin % of Net Revenue	58%	28%	4%	18%	48%	27%	26%	16%	59%	43%	32%	36%	43%	44%	36%
Typical Capital Intensity	Low	Medium	Low	Low	Low	Low	Low	Low	High	Medium	High	High	High	Low	
Waterbury Hospital-specific Capital Intensity	Low	High	Low	Medium	Low	Low	Low	Low	Medium	High	High	High	High	High	

* Data provided by Waterbury Hospital

Fiscal Year 2010 Profitability by Product Line – Net Margin*

Fiscal Year 2010 Profitability by Product Line (in thousands)

	Needs Improvement → Performing														
	Psych	Women & Infants	Cardiology	Observation	Offsite Outpatient Services	Outpatient Labs	GI	Orthopedics	EEG	Sleep Lab	Radiology	All Other Surgery	ER	IP - Medical	Total
Gross Charges	$ 53,751	$ 33,102	$ 116,904	$ 20,360	$ 28,260	$ 22,717	$ 5,142	$ 91,614	$ 1,828	$ 9,196	$ 28,876	$ 164,121	$ 83,215	$ 158,240	$ 817,326
Contractual Allowances (Inferred)	(40,078)	(21,335)	(87,133)	(16,353)	(21,646)	(18,364)	(3,316)	(61,969)	(1,285)	(6,950)	(23,173)	(119,811)	(63,059)	(109,567)	(594,039)
Net Revenue	13,673	11,767	29,771	4,007	6,614	4,353	1,826	29,645	543	2,246	5,703	44,310	20,156	48,673	223,287
Direct Department Cost	(10,370)	(8,382)	(18,000)	(2,793)	(4,444)	(2,830)	(1,109)	(17,678)	(215)	(1,004)	(2,071)	(22,129)	(9,523)	(22,800)	(123,348)
Direct Department Beneifts	(2,697)	(1,476)	(2,340)	(474)	(482)	(361)	(201)	(1,368)	(11)	(155)	(269)	(3,218)	(1,888)	(4,504)	(19,444)
Direct Contribution Margin	606	1,909	9,431	740	1,688	1,162	516	10,599	317	1,087	3,363	18,963	8,745	21,369	80,495
Indirect Fixed Cost	(6,724)	(5,918)	(12,126)	(2,055)	(2,606)	(1,905)	(974)	(10,567)	(138)	(645)	(1,626)	(17,167)	(6,753)	(17,624)	(86,828)
Net Margin	$ (6,118)	$ (4,009)	$ (2,695)	$ (1,315)	$ (918)	$ (743)	$ (458)	$ 32	$ 179	$ 442	$ 1,737	$ 1,796	$ 1,992	$ 3,745	$ (6,333)
Net Margin % of Net Revenue	-45%	-34%	-9%	-33%	-14%	-17%	-25%	0%	33%	20%	30%	4%	10%	8%	-72%

* Data provided by Waterbury Hospital

FY 2010 Discharge Profitability by Payer (Per Discharge)

FY 2010 Inpatient (Per Discharge)	Self Pay	Medicaid	Managed Medicaid	Managed Medicare	Medicare	Managed Care	Commercial	Workers Comp	TOTAL
Gross Charges	$ 32,426	$ 35,668	$ 16,748	$ 50,214	$ 47,408	$ 37,022	$ 37,290	$ 56,594	$ 39,670
Contractual Allowances (Inferred)	(30,462)	(29,495)	(13,030)	(36,599)	(33,813)	(25,064)	(21,667)	(18,628)	(28,217)
Net Revenue	1,964	6,173	3,718	13,616	13,595	11,957	15,624	37,966	11,453
Direct Department Cost	(4,589)	(5,343)	(3,675)	(8,008)	(7,392)	(6,447)	(6,279)	(10,281)	(6,468)
Direct Department Benefits	(767)	(992)	(673)	(1,158)	(1,153)	(807)	(866)	(880)	(980)
Direct Contribution Margin	(3,392)	(163)	(630)	4,449	5,049	4,703	8,479	26,806	4,005
Indirect Fixed Cost	(3,319)	(3,889)	(2,549)	(5,594)	(5,254)	(4,256)	(4,276)	(6,379)	(4,509)
Net Margin	$ (6,711)	$ (4,052)	$ (3,179)	$ (1,145)	$ (205)	$ 448	$ 4,203	$ 20,428	$ (504)

FY 2010 Discharge Profitability by Payer (Total Discharges)

FY 2010 Inpatient (Total)	Self Pay	Medicaid	Managed Medicaid	Managed Medicare	Medicare	Managed Care	Commercial	Workers Comp	TOTAL
Gross Charges	$ 5,544,821	$ 55,391,961	$ 24,904,401	$ 43,184,222	$ 247,517,363	$ 94,331,254	$ 41,765,178	$ 4,980,273	$ 517,619,473
Contractual Allowances (Inferred)	(5,208,930)	(45,805,737)	(19,376,153)	(31,474,805)	(176,539,437)	(63,863,985)	(24,266,635)	(1,639,223)	(368,174,905)
Net Revenue	335,891	9,586,224	5,528,248	11,709,417	70,977,926	30,467,269	17,498,543	3,341,050	149,444,568
Direct Department Cost	(784,757)	(8,298,175)	(5,464,970)	(6,887,025)	(38,594,942)	(16,428,112)	(7,031,942)	(904,721)	(84,394,644)
Direct Department Benefits	(131,110)	(1,540,869)	(1,000,630)	(996,087)	(6,019,739)	(2,054,982)	(969,576)	(77,397)	(12,790,390)
Direct Contribution Margin	(579,976)	(252,820)	(937,352)	3,826,305	26,363,245	11,984,175	9,497,025	2,358,932	52,259,534
Indirect Fixed Cost	(567,593)	(6,039,976)	(3,789,925)	(4,810,651)	(27,431,102)	(10,843,401)	(4,789,552)	(561,312)	(58,833,512)
Net Margin	$ (1,147,569)	$ (6,292,796)	$ (4,727,277)	$ (984,346)	$ (1,067,857)	$ 1,140,774	$ 4,707,473	$ 1,797,620	$ (6,573,978)

Section 6
Initiatives Dashboard

PRICEWATERHOUSECOOPERS

Initiative Dashboards

Current initiative dashboards were reviewed and resulted in the following findings:

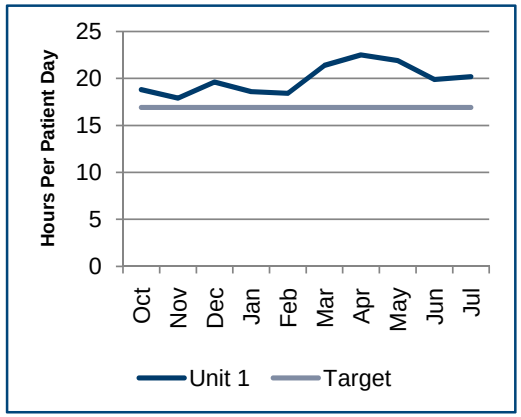
- All initiative dashboards are prepared by Executive Director of Process Improvement, Randy Essenberg, and populated on the internal website for board and management review
- A total of approximately 45 initiative dashboards are managed and available for reference (see following slide)
- It is reported that initiative dashboards are not consistently reviewed and prioritized by board members
- It is reported that management does not regularly respond to issues presented in the initiative dashboards
- Sample trending based on the target and actual metrics outlined in the dashboards for nursing and linen utilization initiatives are provided on the following slides

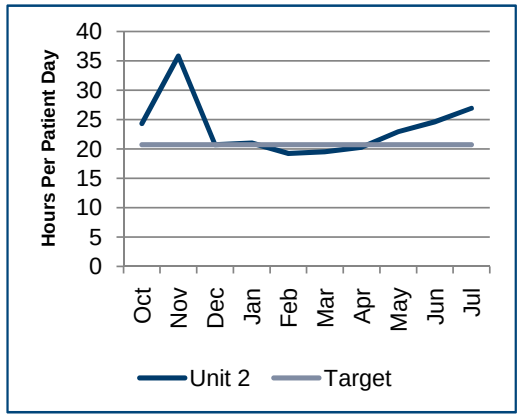
Initiative Dashboards

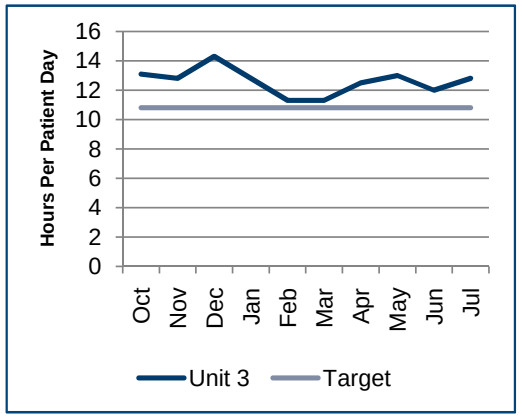
Below is a list of the available initiative dashboards:

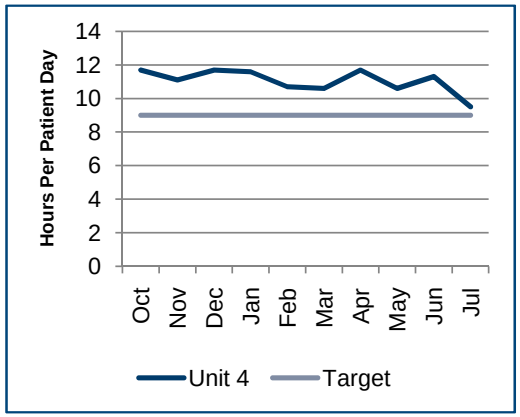
- Outpatient Testing
- Sleep Lab
- Cardiology
- EEG
- GI
- Outpatient Medical Therapies
- Floats
- Nursing Unit Summary
- Ortho Unit
- Surgical Unit
- Telemetry
- Medical Unit P5
- CVU
- Critical Care
- Post Anesthesia Care Unit
- Central Sterile Processing
- Operating Room
- Labor Prod./Var. Lbr Optimize
- Linen Utilization
- Materials Management
- Non-Salary Initiatives
- OP BEH
- Overtime Utilization
- Patient Throughput
- Pharmacy
- Plant
- Public Relations/Community Health Education
- Radiology/Imaging Services
- Revenue Cycle
- Safety/Security
- Top 20 DRGs LOS
- Acute Care Behavioral Health
- Bed Control
- Board Quality and Safety Committee
- Cerner Implementation
- Adol and Child
- Clinical Engineering
- Crisis
- Dietary
- Emergency Department Throughput
- FBC and SCN
- Finance
- Infection Prevention Program
- Information Technology
- Laboratory

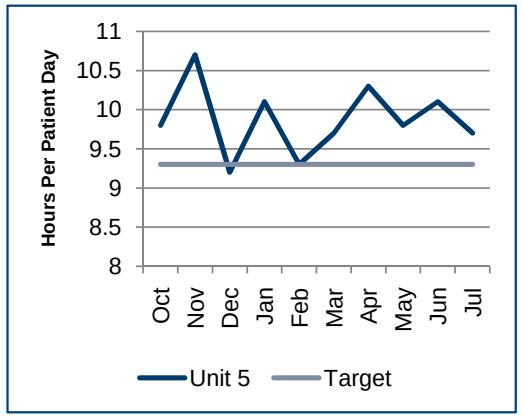
Initiatives - Labor Productivity: Nursing

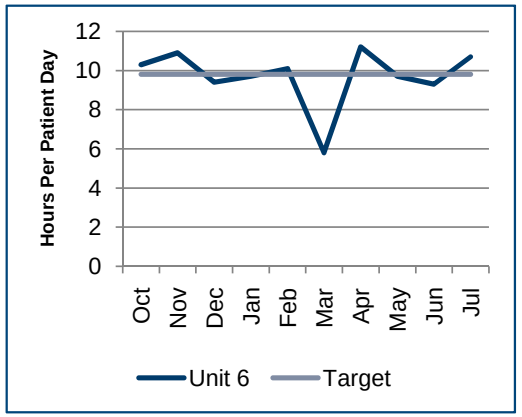




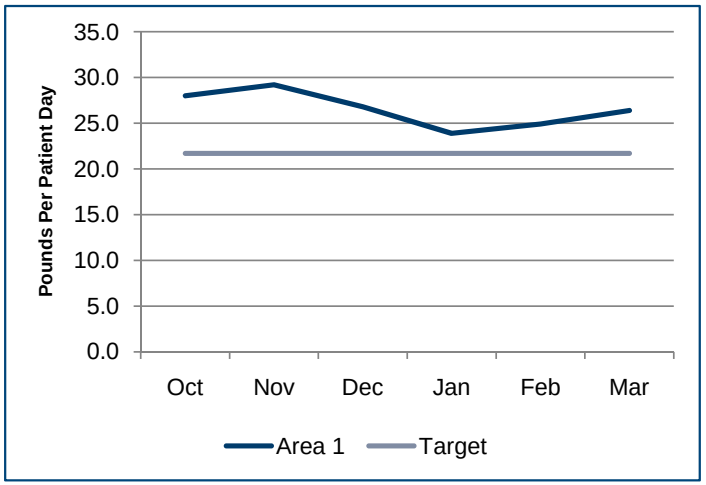


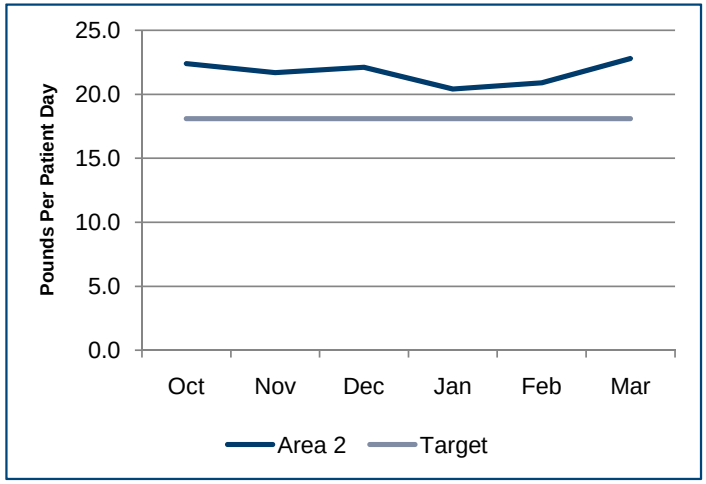


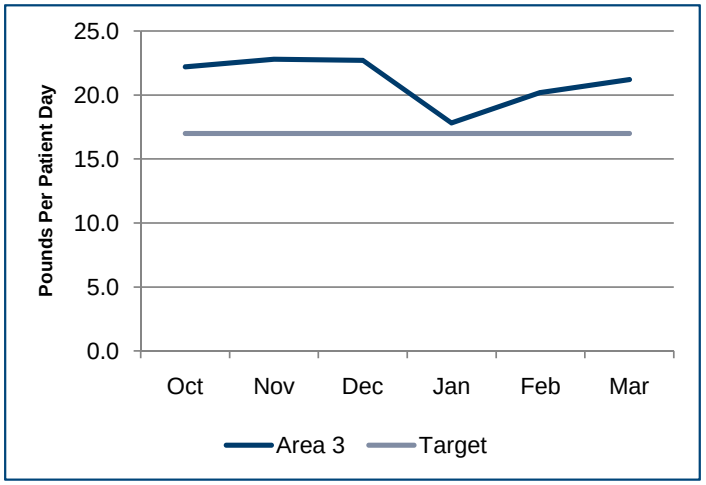


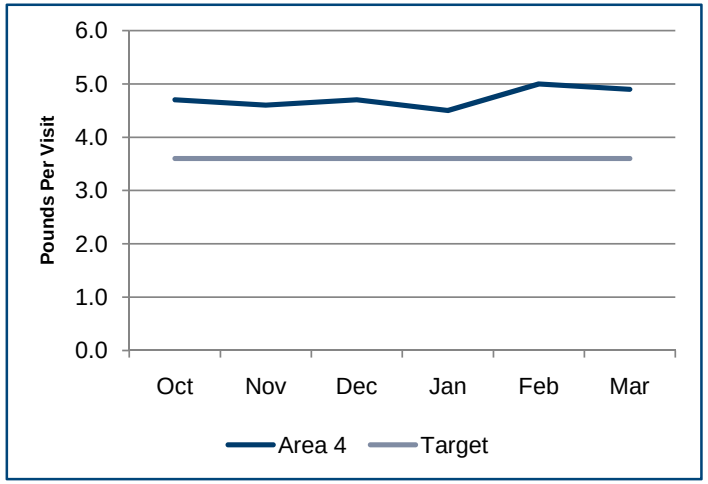


Initiatives – Linen Utilization









Section 7
Leading Indicators

PRICEWATERHOUSECOOPERS

Recommendations – Monthly Financial Statements Package

Leading Indicators:

- Operating Statistics

	Current Month				Year-to-Date			
	Actual	Budget	Variance	Prior Year	Actual	Budget	Variance	Prior Year
Inpatient Statistics								
Discharges								
Patient Days								
ALOS								
Occupancy Percentage (Staffed Beds)								
Case Mix Index:								
Medicare								
Total								
Surgical Statistics								
Inpatient Surgery								
Outpatient Surgery								
Outpatient / ER Statistics								
Outpatient Cases								
ED Visits:								
Discharged								
Admitted								
Observation Cases								
Cash Collected								
Total Cash Collected								
Payor Mix % (Based on Gross Revenue)								
Medicare								
Managed Medicare								
Medicaid								
Managed Medicaid								
Commercial								
Managed Care								
Self Pay								
Total								

Recommendations – Monthly Financial Statements Package (continued)

Leading Indicators (continued):

- Financial Ratios and Labor Statistics

Key Financial Ratios	Year-to-Date				Comparator Group			
	Actual	Budget	Variance	Prior Year	Peer Group	S&P BBB	Fitch BBB	Moody's Baa2
Operating Performance								
Operating Margin								
Excess Margin								
Bad Debt as a % of Gross Revenue								
Liquidity								
Days Cash on Hand								
Days in Net Accounts Receivable								
Days in Accounts Payable								
Leverage								
Long-Term Debt to Equity								
Long-Term Debt to Capitalization								
Annual Cash Flow to Total Liabilities								
Unrestricted Cash to Debt								
Maximum Debt Service Coverage								
Average Age of Plant								

Labor and Productivity Statistics	Current Month				Year-to-Date			
	Actual	Budget	Variance	Prior Year	Actual	Budget	Variance	Prior Year
FTEs:								
Routine								
Ancillary								
Support								
Total FTEs								
FTEs per Adjusted Occupied Bed								
FTEs per Equivalent Discharge								

Recommendations – Monthly Financial Statements Package (continued)

Leading Indicators (continued):

- Statement of Operations and Balance Sheet

Statement of Operations	Current Month				Year-to-Date			
	Actual	Budget	Variance	Prior Year	Actual	Budget	Variance	Prior Year
Revenue								
Gross Revenue								
Contractual Allowances								
Other Allowances								
Net Revenue								
Other Operating Income								
Total Revenue								
Expenses								
Salaries and Benefits								
Non-Salary Expenses								
Depreciation								
Interest								
Alliance Medical Group								
Operations Improvement								
Total Expenses								
Income/(Loss) from Operations								
Non-Operating Income								
Non-Operating Income								
Change in Unrealized Gains and Losses								
Net Income/(Loss)								

Recommendations – Monthly Financial Statements Package (continued)

Leading Indicators (continued):

- Statement of Operations and Balance Sheet (continued)

Balance Sheet	Current Month			
	Actual	Budget	Variance	Prior Year
Assets				
Cash & Cash Equivalents				
Net Accounts Receivable				
Due from Affiliates				
Assets Whose Use is Limited				
Other Investments				
Net Property, Plant & Equipment				
Other Assets				
Total Assets				
Liabilities & Net Assets				
Accounts Payable				
Accrued Expenses				
Accrued Pension				
Long-Term Debt				
Due to Third-Party Payors				
Other Liabilities				
Net Assets				
Total Liabilities & Net Assets				

Recommendations – Monthly Financial Statements Package (continued)

Narrative to Monthly Financial Statements

- Management's observations and evaluation of the monthly and year-to-date results should be included in the monthly financial statement package every month. This narrative should be included as the first section of the monthly financial statement package
- This should include observations around comparisons of current month and year-to-date results to budget and to prior year

Leading Indicators

- Enhance current page one of the monthly financial statement package, entitled 'Executive Summary'
- Add month-to-date results
- Add month-to-date comparisons to budget and prior year
- Add year-to-date comparisons to prior year
- Reformat (see the previous few pages for suggested layout)

Recommendations – Monthly Financial Statements Package (continued)

Comparative Income Statement

- Add month-to-date results
- Add month-to-date comparisons to budget and prior year
- Reformat ($s / underlines / etc.)

Income Statement

- Add operating margin and excess margin %s by month
- Reformat ($s / underlines / etc.)

Comparative Balance Sheet

- Reformat ($s / underlines / etc.)

Statement of Cash Flows

- Add monthly detail for the current fiscal year (currently includes current month only)
- Reformat ($s / underlines / etc.)

Recommendations – Monthly Financial Statements Package (continued)

Payroll Hours All Departments

- Reevaluate the purpose and usefulness of this schedule
- See suggested labor statistics in leading indicators presentation

Gross A/R Aging

- Reformat schedule
- The following two pages represent a suggested format for the accounts receivable analysis:

Accounts Receivable Analysis

	Sep '10 A/R	% of Gross A/R	Oct '10 A/R	% of Gross A/R	Nov '10 A/R	% of Gross A/R
Gross A/R	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**
Less:						
Contractual Allowances		0.0%		0.0%		0.0%
Reserve for Bad Debt		0.0%		0.0%		0.0%
Reserve for Free Care		0.0%		0.0%		0.0%
Subtotal Reserves		**0.0%**		**0.0%**		**0.0%**
Net A/R per Financials	**$ -**	**0.0%**	**$ -**	**0.0%**	**$ -**	**0.0%**

Recommendations – Monthly Financial Statements Package (continued)

Gross A/R Aging (continued):

Accounts Receivable Aging Analysis								
9/30/2010								
Financial Class	**In-House**	**0-30**	**31-60**	**61-90**	**91-150**	**151-365**	**1+ Year**	**Total**
Blue Cross	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Blue Cross HMO								-
Blue Cross PPO								-
Commercial HMO								-
Commercial Insurance								-
Commercial PPO								-
Managed Medicaid								-
Managed Medicare								-
Medicaid								-
Medicare								-
SAGA								-
Self Pay								-
Workers Compensation								-
Total 9/30/2010	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
% of Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total 9/30/2009	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
% of Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Total Change	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
% Change	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

Recommendations – Monthly Financial Statements Package (continued)

Key Inpatient Indicators / Key Outpatient Indicators

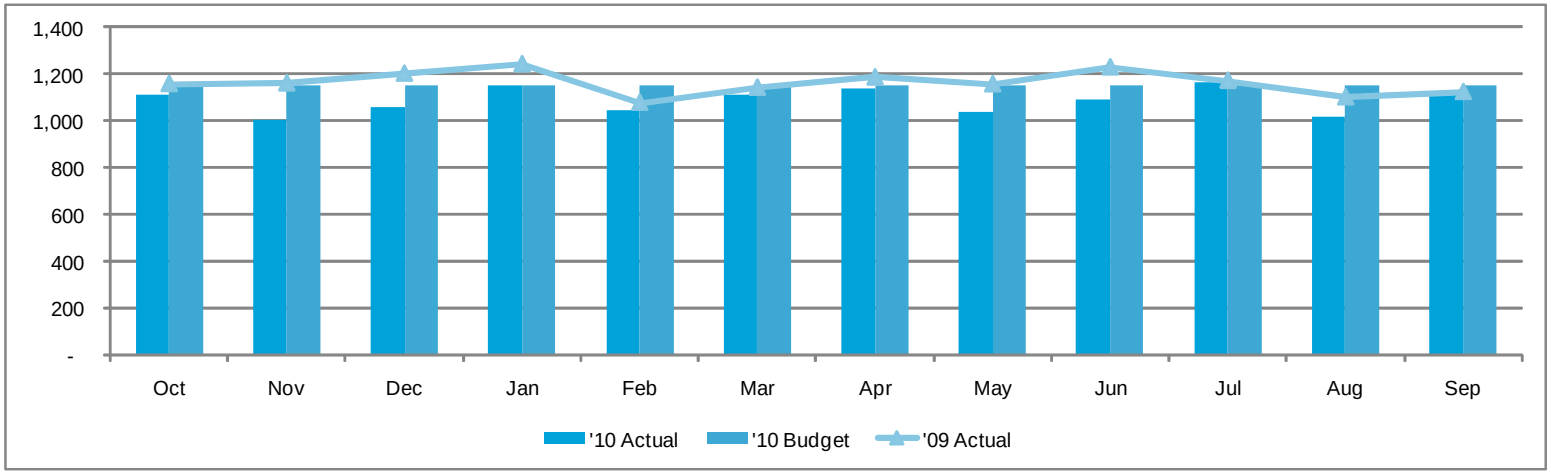
- The following is the suggested change to the current format (develop for Patient Days, ALOS, Outpatient Cases, ED Cases and OR Volume as well):

Admissions

YTD	'10 Actual	'10 Budget	'09 Actual
Total	13,046	13,787	13,928

YTD	'10 Budget	'09 Actual
Variance	(741)	(882)

YTD	'10 Budget	'09 Actual
Percent of	-5.7%	-6.8%



Trend	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
'10 Actual	1,113	1,002	1,060	1,153	1,044	1,113	1,138	1,038	1,093	1,163	1,019	1,110	13,046
'10 Budget	1,148	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	1,149	13,787
'09 Actual	1,156	1,159	1,200	1,240	1,076	1,140	1,184	1,155	1,227	1,170	1,099	1,122	13,928

Recommendations – Monthly Financial Statements Package (continued)

Net Revenue and Expenses per Equivalent Admission Graph

- Reevaluate the purpose and usefulness of this graph
- If the graph is necessary, reformat the layout

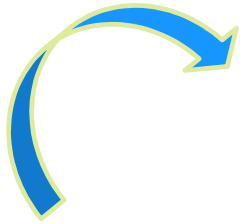
Expense Categories as % of Total (Excluding OI and AMG) Graph

- Reevaluate the purpose and usefulness of this graph
- If the graph is necessary, reformat the layout

Section 8
Future Considerations

PRICEWATERHOUSECOOPERS

Three Steps of Health Reform



Bending the cost curve (2015-2020)

- Penalty for not adopting electronic medical records
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax
- Medicare Part D "Doughnut Hole" closes
- Reduced payment for hospital-acquired conditions

Major expansion of coverage (2014)

- Mandates for individuals
- Employer penalties for those that do not provide coverage
- Health insurance exchanges
- Small employer and individual subsidies
- Health insurer industry fee
- Guaranteed issue, rating bands, and risk adjustment
- Medicaid expansion
- Disproportionate share payment reductions to hospitals

Regulation and coverage (2010-2013)

- Elimination of pre-existing coverage exclusions for children and lifetime coverage limits and rescissions; dependent coverage through age 26
- MLR minimums for non-grandfathered plans
- Medicare Part D gap narrows, Medicare Advantage rates frozen, bonuses available, beneficiary rebates, free preventive care
- Temporary high risk pools
- Fee on brand -name pharmaceutical manufacturers
- Community Living and Support Services Act (CLASS Act)

Three Steps of Health Reform

2010

- Physician-owned hospital Medicare provider agreements must be in place
- New exemption requirements for tax-exempt hospitals
- Reduction in annual market basket update to Medicare providers
- Enhanced Medicare and Medicaid provider screenings

2011

- Grants for medical malpractice reduction demonstration projects
- 10% Medicare bonus for primary care and general surgeons in a health professional shortage area (ends 2015)
- Prohibit federal Medicaid payments for HAC
- Federal funding of Medicaid medical home
- New funding for community health centers, school-based clinics, and trauma center program

2012

- Accountable care organizations (ACOs)
- Medicare payments reductions for preventable readmissions
- Medicare value-based purchasing for hospitals
- Medicaid bundled payment demonstrations

2013

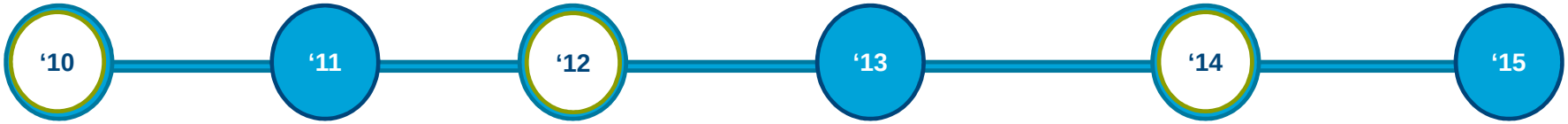
- Medicare bundled payment demonstration
- Increase Medicaid primary care payments
- Financial relationship disclosure requirements
- Value-based payment for physician fee
- Community needs assessment to be completed and implemented

2014

- Expand Medicaid
- Disproportionate Share Hospital (DSH) reductions

2015

- Reduce Medicare payments for hospital-acquired conditions by 1%
- Penalties for providers that have not achieved meaningful use of EHRs (HITECH Act)



"4 Key Themes" of Healthcare Reform

HOW do you measure up?

- Quality and efficiency will increasingly impact how providers are paid.
- Focus is on all the additional ways providers will be evaluated, compared and reported.
- Clients should know how they will be measured and what they can do to improve the results.

HOW do you thrive on governmental reimbursement?

- More revenue under health reform, but increasingly restrictive government sector payments bring continued challenges to providers.
- An ever increasing percentage of patients paid under governmental rates, over next 10 year >10% increase could be expected.
- Cost containment and efficient delivery of services will be needed for success.

"4 Key Themes" of Healthcare Reform

HOW do you think outside of this box?

- A provider's ability to manage across the entire continuum of care will increasingly impact its viability.
- PwC's clients (primarily Hospitals and Health Systems) need to consider impact of the legislation on the broader health delivery system.
- Clients should focus on defining and delivering cost effective and high quality care.

HOW do you ensure you are doing the right thing?

- Health reform increases our regulatory environment but also puts heightened focus on community needs and tax-exempt status.
- Expansion in regulatory environment of healthcare and more public disclosure means risks associated with compliance is increasing.
- Compliance should be treated as a fundamental part of doing business not as an independent discrete function.

Future Considerations

The following are regulatory and health care reform related items that must be considered over the next few years:

- No increases in Government payments
- Payment reductions for quality:
  - Readmissions
  - Hospital acquired conditions (HACs)
  - Value Based Purchasing
- Meaningful use
- ICD-10
- HIPAA 5010
- Community Needs Assessment
- Red Flags
- RACs
- Accountable Care Organizations/Bundled Payments/Capitation

Impact of Quality Incentives and Paying for Health Reform

What institutions should expect in terms of revenue trends under health reform:

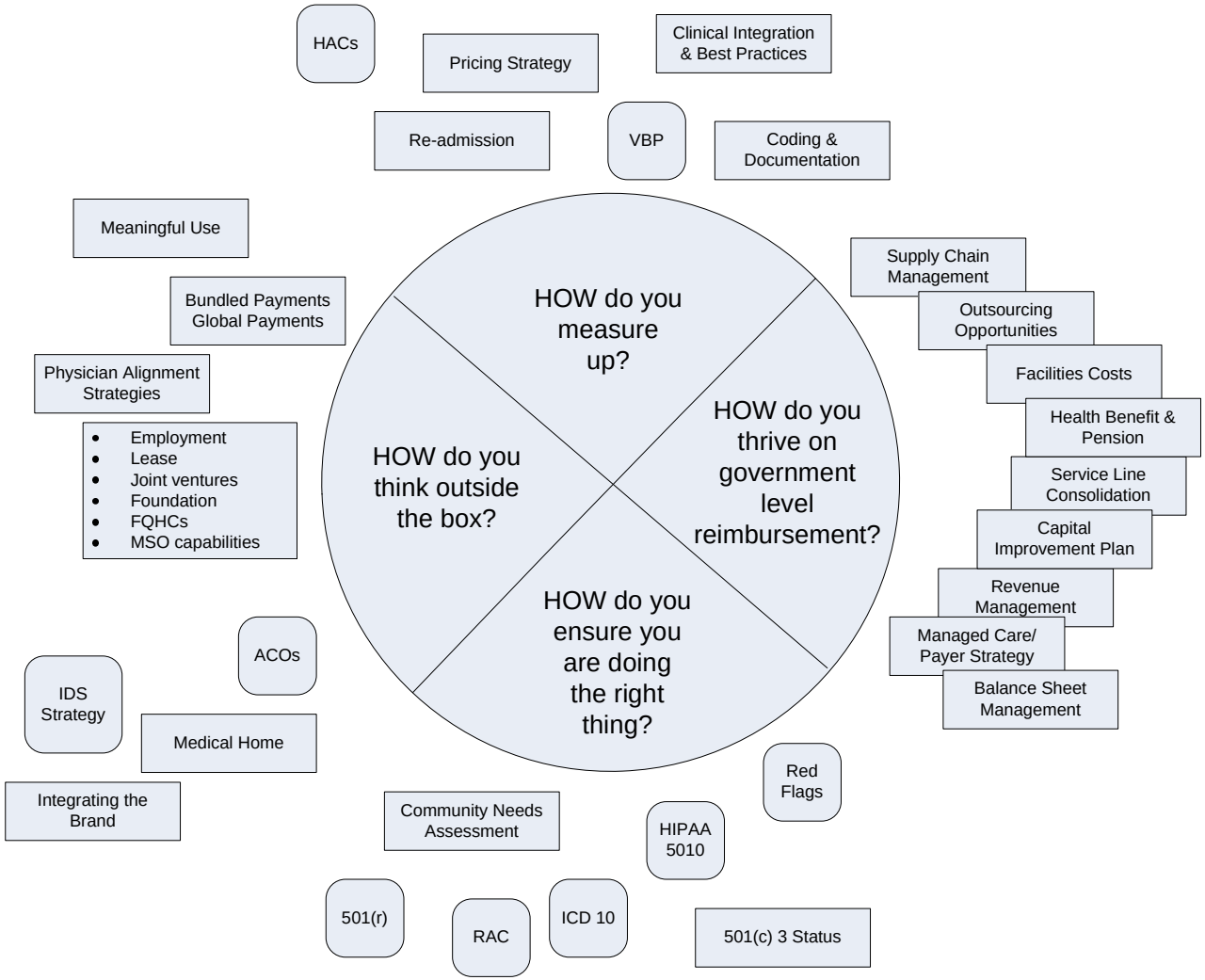
- Medicare – a cumulative 3 to 13% decrease in inpatient payments from 2011 to 2015 and similar trends in outpatient activity; and a cumulative 15 to 26% differential relative to market basket
- Medicaid – currently uninsured will shift into Medicaid creating a boost in Medicaid volume. However, given budget constraints at the state level, can any increases be expected for at least a couple of years?
- Exchanges – currently uninsured will shift into programs through the exchanges, but can it be expected that payment levels will be much greater than Medicare?
- Commercial – no better than inflationary increases. In addition, depending on the nature of employer groups, some level of existing volume under commercial insurance will shift to exchange programs
- Self-pay – the level of uninsured may decrease, however, secondary self pay will continue to escalate

Projected Medicare IPPS Update

Medicare Market Basket Update - Without Reductions for Readmissions, Hospital Acquired Conditions, and Value Based Purchasing								
Federal Fiscal Year	Projected Market Basket Increase	Market Basket Reduction per PPACA[1]	Productivity Adjustment[2]	Behavioral Offset[3] (Case Mix)	Readmissions[4]	Hospital Acquired Conditions[5]	Value Based Purchasing[6]	Total Projected Reimbursement Impact
2011	2.60%	-0.25%		-2.90%				-0.55%
2012	2.10%	-0.10%	-1.30%	-2.90%				-2.20%
2013	2.40%	-0.10%	-1.30%	-1.90%	0%		0%	-0.90%
2014	2.70%	-0.30%	-1.30%	-1.90%	0%		0%	-0.80%
2015	2.90%	-0.20%	-1.30%		0%	0%	0%	1.40%
Total	**12.70%**	**-0.95%**	**-5.20%**	**-9.60%**	**0%**	**0%**	**0%**	**-3.05%**
Projected Market Basket Increase								**12.70%**
Difference Between Market Basket (Inflation) and Update								**-15.75%**

Medicare Market Basket Update - <u>With</u> Reductions for Readmissions, Hospital Acquired Conditions, and Value Based Purchasing								
Federal Fiscal Year	Projected Market Basket Increase	Market Basket Reduction per PPACA[1]	Productivity Adjustment[2]	Behavioral Offset[3] (Case Mix)	Readmissions[4]	Hospital Acquired Conditions[5]	Value Based Purchasing[6]	Total Projected Reimbursement Impact
2011	2.60%	-0.25%		-2.90%				-0.55%
2012	2.10%	-0.10%	-1.30%	-2.90%				-2.20%
2013	2.40%	-0.10%	-1.30%	-1.90%	-1.00%		-1.00%	-2.90%
2014	2.70%	-0.30%	-1.30%	-1.90%	-2.00%		-1.25%	-4.05%
2015	2.90%	-0.20%	-1.30%		-3.00%	-1.00%	-1.50%	-4.10%
Total	**12.70%**	**-0.95%**	**-5.20%**	**-9.60%**	**-6.00%**	**-1.00%**	**-3.75%**	**-13.80%**
Projected Market Basket Increase								**12.70%**
Difference Between Market Basket (Inflation) and Update								**-26.50%**

The health system of tomorrow will not be the same as today's



Disclaimer

Our Services were performed and this Report was developed in accordance with our engagement letter dated November 5, 2010 and are subject to the terms and conditions included therein.

Our Services were performed in accordance with Standards for Consulting Services established by the American Institute of Certified Public Accountants ("AICPA"). Accordingly, we are providing no opinion, attestation or other form of assurance with respect to our work and we did not verify or audit any information provided to us. Our work was limited to the specific procedures and analysis described herein and was based only on the information made available through November 2010. Accordingly, changes in circumstances after this date could affect the findings outlined in this Report.

This information has been prepared solely for the use and benefit of, and pursuant to a client relationship exclusively with Waterbury Hospital. PwC disclaims any contractual or other responsibility to others based on its use and, accordingly, this information may not be relied upon by anyone other than Waterbury H.

This document is provided as part of a more comprehensive oral report and is not considered complete without the accompanying oral report.

EXHIBIT Q5-3

CONFIDENTIAL INFORMATION MEMORANDUM

Confidential Information Memorandum

September 2012

*Memorandum:*_____

CAIN BROTHERS

This Confidential Information Memorandum ("CIM") has been prepared on behalf of Greater Waterbury Health Network, Inc. and its wholly owned subsidiaries and affiliated entities (collectively, the "Company") based on information from the Company and published sources, and is being furnished through Cain Brothers, as the Company's exclusive authorized representative, for informational purposes solely for use by qualified prospects in considering their interest in entering into a partnership, purchase, merger or other form of business combination with the Company (a "Transaction"). The information contained herein is subject to change without notice. Neither the Company nor Cain Brothers assumes any responsibility to update any information contained in this CIM or to inform the recipient of information which may affect this CIM. This CIM has been prepared to assist interested parties in making their own evaluation of the Company and does not purport to be all-inclusive or to contain all information that a prospective party to a Transaction may desire or that may be required in order to properly evaluate the business, prospects or value of the Company. In all cases, interested parties should conduct their own investigation and analysis of the Company and the data set forth in this CIM. Industry data and statistics have been obtained or derived from the Company and published industry sources.

By accepting this CIM, the recipient acknowledges and agrees that all of the information contained herein is highly confidential and subject to the Non-Disclosure Agreement ("NDA") executed by the recipient. Without limiting the generality of the foregoing: (1) the recipient will not reproduce this CIM in whole or in part; (2) if the recipient does not wish to pursue a Transaction relating to the Company, it will (i) promptly return to Cain Brothers hard copies and delete electronic copies of this CIM, together with any other materials relating to the Company which the recipient may have received in written or electronic form from the Company, Cain Brothers or any of their respective subsidiaries or affiliates and (ii) take such other actions, if any, required by the NDA; (3) the recipient will hold all information and the fact that it is involved in any process relating to the Company and the status thereof as confidential; and (4) any proposed actions by the recipient which are inconsistent in any manner with the NDA will require the prior written consent of the Company.

Cain Brothers has not independently verified any of the information contained herein, and neither the Company, Cain Brothers nor any of their respective affiliates makes any representation or warranty (expressed or implied) as to the accuracy or completeness of this CIM or any statements, estimates or projections contained herein. Such statements, estimates and projections reflect various assumptions made by the Company concerning anticipated results, which are subject to business, economic and competitive uncertainties and contingencies, many of which are beyond the control of the Company and which may or may not prove to be correct. As a result, no representation or warranty is made as to the feasibility or attainability of the projected financial information or the accuracy or completeness of the assumptions from which the projected financial information is derived. There can be no assurance that the projections will be realized. This CIM speaks only as of the date hereof or as of the date indicated. This CIM does not constitute an offer or invitation for the sale or purchase of the securities, assets or business described herein. The only information that will have any legal effect will be that specifically represented, warranted and contained in a definitive agreement relating to a Transaction and executed by the Company and a prospective Transaction party. The Company and Cain Brothers disclaim liability for any loss or damage incurred as a result of any information contained in or omitted from this CIM.

The Company reserves the right to negotiate with one or more qualified prospects at any time and to enter into a definitive agreement relating to a Transaction without prior notice to the recipient or other prospective Transaction parties. Further, the Company reserves the right, at any time, to terminate the process and / or to modify any procedures without giving advance notice or providing any reason therefore. The Company also reserves the right during the evaluation period to take any action, whether within or outside the ordinary course of business.

INFORMATION REQUESTS

Cain Brothers is the Company's exclusive financial advisor. Under no circumstances should any interested party directly contact the Company, any of its trustees, employees, medical staff, patients or suppliers, for any reason in connection with their evaluation of the Company. All inquiries regarding this Confidential Information Memorandum or the Company should be directed to the following persons:

James Cain	**Jason D. Horowitz**	**Nichole Kim**
Managing Director	Senior Vice President	Analyst
(212) 981-6955	(212) 981-6951	(212) 981-6919
jcain@cainbrothers.com	jhorowitz@cainbrothers.com	nkim@cainbrothers.com

Cain Brothers & Company, LLC
360 Madison Avenue, 5th Floor
New York, New York 10017
Telephone: (212) 869-5600

Table of Contents

I. Process Overview

A. Organization

Greater Waterbury Health Network, Inc. (together with its affiliates, "GWHN," the "Network," or the "Company") (http://www.waterburyhospital.org) is a Connecticut non-stock, 501(c)(3) corporation. GWHN consists of numerous legal entities, joint ventures ("JVs") and affiliations, including The Waterbury Hospital (the "Hospital" or "Waterbury Hospital"). The Hospital, a 357-licensed bed acute-care teaching hospital provides a comprehensive range of inpatient, outpatient and ancillary services for residents of Waterbury and the surrounding community. The Hospital is located near the intersection of Route 8 and Interstate 84 and currently staffs over 1,250 full-time equivalents ("FTEs"), of which 74 are employed physicians. There are 362 active medical staff members.

B. Objectives

GWHN's Board of Directors (the "Board") has engaged Cain Brothers to explore strategic alternatives, which may include a partnership, merger or sale. At the Board's direction, Cain Brothers is requesting proposals from a select group of organizations interested in a strategic relationship with GWHN. The core objective is to ensure GWHN's continued long-term vigor as a provider of leading health care services to the Greater Waterbury community. As such, GWHN intends to evaluate potential partners who can demonstrably help in achieving the following objectives (the "Objectives"):

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

The Board is therefore requesting proposals from a select group of organizations that can demonstrate that they cannot only meet these objectives, but are willing to commit to a shared cultural vision of ensuring cost-effective, high quality care with appropriate charitable care commitments. Further, such organizations will need to demonstrate their ability to complete a transaction within ***a reasonable*** time frame.

C. Recent Events

In August 2011, GWHN entered into a letter of intent, whereby a joint venture would be created with LHP Hospital Group ("LHP") and Saint Mary's Health System ("SMH") (combined, the "JV"). The JV ownership would have been divided among the three parties: LHP with an 80% interest, GWHN and SMH each owning a 10% interest. Governance in the for-profit entity would be shared among all three parties. The JV would have committed to operate its healthcare facilities in accordance with both the community benefit standards applicable to not-for-profit health systems and with the Ethical and Religious Directives for Catholic healthcare services ("ERDs"). Furthermore, as part of the proposed agreement, LHP, through the JV, planned to invest $400 million to construct a new state-of-the-art medical center that would replace both the Waterbury Hospital and SMH hospitals.

After a year of intense negotiations among the parties, community leaders and government officials, it became increasingly clear that there were still many impediments to the transaction. In September 2012, the proposed JV was terminated by LHP. The reasons cited included the increasing costs of building the replacement hospital and the inability to satisfy regulators over issues related to ERDs.

Over the same time period, the competitive landscape in Connecticut changed. Many community hospitals are strategically aligning with stronger, regional partners, consolidating among themselves, or embarking on other strategic initiatives alternatives. For example, Yale-New Haven Hospital acquired the Hospital of Saint Raphael in September 2012. The Western Connecticut Health Network, first developed in July 2010 through the merger of Danbury Hospital and New Milford Hospital, announced in early 2012 that it was exploring a partnership with Norwalk Hospital. Finally, two other organizations, Eastern Connecticut Health Network and Bristol Hospital and Health Care Group recently announced their desire to pursue transactions.

As a result, it has become increasingly important for GWHN to rapidly assess its alternatives for the future.

D. Phase I – Preliminary, Non-Binding Proposals

GWHN, through Cain Brothers, is inviting organizations to ***submit a written, preliminary, non-binding indication of interest and value ("Preliminary Proposals")***, based on the information provided herein and/or related information provided by the GWHN.

Your proposal should be submitted electronically no later than ***5:00 pm Eastern Standard Time on October 12, 2012*** in Microsoft Word® format to Jason D. Horowitz (jhorowitz@cainbrothers.com). Any additional materials supplementing your proposal may be submitted in Adobe PDF® or other electronic format.

After receipt of Preliminary Proposals, GWHN plans to select a limited number of participants to continue to the next round of the process.

GWHN requests that the proposal be as specific and detailed as possible. In order to be considered responsive and to allow for appropriate analysis, proposals should address the elements outlined in Appendix A in the order presented.

Site visits at GWHN facilities, management discussions and limited additional diligence through an established virtual data room will be available prior to the first proposal submission deadline. A Cain Brothers' representative will be available to schedule such requests.

Please do not contact any members of the GWHN's Board of Directors, the Hospital's Trustees, management, or staff without the prior consent of Cain Brothers. Such contact could result in the disqualification for further consideration.

Once received, Cain Brothers will review your proposal and follow-up with any aspects of your proposal that may need elaboration or clarification.

E. Phase II – Detailed Due Diligence and Binding Proposals

Phase II is intended to provide the information that a qualified respondent will need in order to submit a binding proposal. Diligence will primarily be conducted through the GWHN virtual data room, though site visits and meetings with management may be given in select circumstances.

In order to maintain an orderly and consistent flow of information to Phase II participants, any requests for additional due diligence information should be submitted to Cain Brothers in writing or electronically. Cain Brothers will distribute responses to information requests to all Phase II participants.

A binding, definitive proposal will be due following the completion of the due diligence process. This proposal will include a markup of a Definitive Agreement to be provided by GWHN prior to submission of the binding proposal. As soon as feasible, following the submission of a binding proposal, GWHN, with the advice of Cain Brothers and GWHN's legal counsel, will evaluate the proposal to determine if it will be presented to GWHN's Board.

GWHN shall have no obligation to accept any proposal, whether or not such proposal represents the best offer for GWHN. An offer will be accepted only upon the execution and delivery of a Definitive Agreement. Until such time that a Definitive Agreement has been executed, GWHN will not have any obligation to any potential partner with respect to any transaction involving GWHN. Following such time, GWHN's only obligation will be as set forth in a Definitive Agreement.

F. Changes to the Selection Process

GWHN's goal is to identify a candidate with whom to complete a transaction meeting the Objectives as quickly as feasible. Therefore, GWHN expressly reserves the right to consider any and all factors in the selection of a proposal and to deal with any party individually or simultaneously with other candidates. GWHN may alter these and any other procedures, as it deems necessary and appropriate. GWHN also reserves the right, at its sole discretion, to reject any and all expressions of interest or proposals and to terminate the process in its entirety, or with respect to any candidate, at any time.

G. Costs and Expenses

Each participant agrees to bear all costs of its own investigation and evaluation of the operations of GWHN, including the fees and disbursements to its own counsel and advisors. No finders' fees, brokers' fees, or commissions will be paid by GWHN, except to its own advisors, in connection with any transaction which may result.

II. Executive Summary

A. Background

GWHN is a Connecticut non-stock, 501(c)(3) corporation consisting of four (4) active wholly-owned subsidiaries, the largest of which is The Waterbury Hospital. Waterbury Hospital, the first hospital in the City of Waterbury and fourth in the State of Connecticut, opened in 1890, after nearly a decade of fundraising.

The Company's Objectives are to assure GWHN's continued long-term vigor as a provider of leading health care services to the Greater Waterbury community. Based on this overarching goal, GWHN intends to evaluate potential partners who can achieve the Objectives:

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

B. Overview

Waterbury Hospital provides a comprehensive range of inpatient, outpatient and ancillary services for residents of Waterbury and the surrounding community. The Hospital is a 357-bed teaching facility located at 64 Robbins Street in Waterbury, Connecticut near the intersection of Route 8 and Interstate 84.

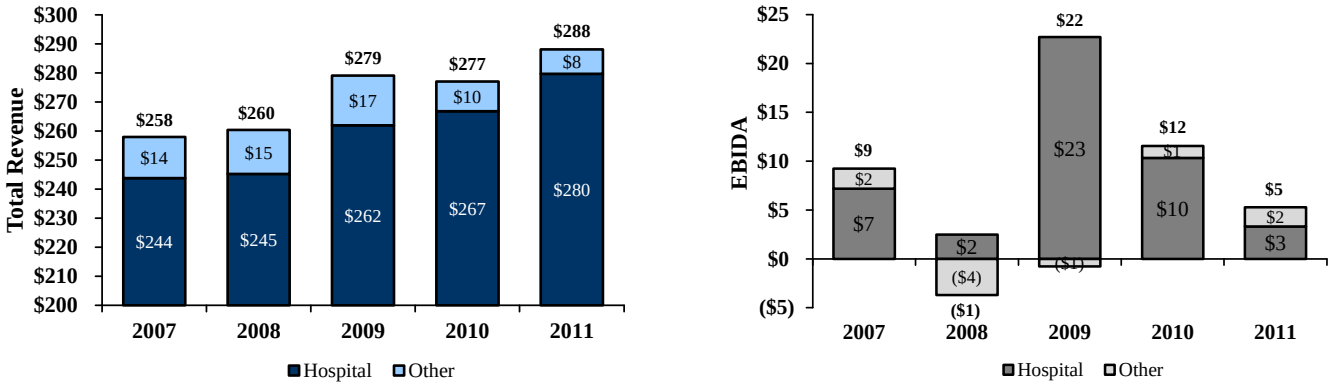
As of August 31, 2012, the Hospital staffs over 1,250 FTEs, including 362 active medical staff members.

The Hospital and its related subsidiaries, which accounted for 97.1% of the GWHN's revenue in fiscal year ending September 30, 2011, has experienced a compounded annual revenue growth rate of 3.5% over the past four fiscal years.

The Hospital and its related subsidiaries also accounted for 62.6% of GWHN's earnings before interest, depreciation and amortization ("EBIDA") in FY 2011.

Table 2.1: Summary Operating Results

($ in millions)



Note: Fiscal year ends September 30

Table 2.2: Key Hospital Only Utilization Statistics

	2008	2009	2010	2011	For the 10 Months Ended July 31, 2012
Licensed Beds	357	357	357	357	357
Average Length of Stay	4.81	4.86	4.54	4.61	4.71
Inpatient Admissions	14,743	13,928	13,046	12,758	10,251
Patient Days	70,879	67,682	59,271	58,780	48,240
Births	1,287	1,221	1,125	1,124	939
Average Daily Census	194	185	163	161	159

Note: Fiscal year ends September 30

Table 2.3: Hospital and Related Subsidiaries Summary Financial Information

($ in millions)

	Fiscal Year Ended September 30,					
	2007	2008	2009	2010	2011	LTM July 2012
Total Revenue	$243.8	$245.2	$261.9	$266.8	$279.7	$285.0
Total Operating Expenses	248.9	254.5	263.2	270.6	287.2	287.3
EBIDA[(1)]	7.2	2.5	22.7	10.3	3.3	8.7
Operating Income[(1)]	(3.4)	(7.6)	13.1	0.7	(6.0)	(1.0)
Excess Revenue Over Expenses	(4.3)	(8.5)	0.5	(3.8)	(8.5)	(2.9)
Capital Expenditures	4.7	4.1	2.0	5.5	15.6	13.3

Note: Fiscal year ends September 30

(1) Excludes one-time fees including operations improvement expenses

III. Key Investment Considerations

GWHN represents a unique and attractive opportunity for a potential partner to grow in the Southern New England region. GWHN is one of the oldest and well-respected health providers in the Southern New England region, demonstrating leadership, innovation, and high quality service for over a century.

Unique Acquisition Opportunity with Significant Financial Enhancement Potential

GWHN offers a potential partner a well-established system with substantial upside potential. The Hospital represents an excellent opportunity in the Central Connecticut market. While the Hospital has a firmly established market position, it requires additional resources and expertise to further unlock its potential through enhancement of physician recruitment and marketing efforts and leveraging of operational costs, including information technology infrastructure costs and facility upgrades.

- **Physician Recruitment and Service Line Expansion.** Considerable opportunity exists through enhanced physician recruitment efforts to increase patient volumes by expanding specialist recruitment efforts.

- **Low-Cost Provider with Regional Outreach Programs:** GWHN provides a community-based provider platform as a cost efficient solution for potential tertiary / quaternary and other regional high-cost providers. As health care reform takes hold, such service utilization is imperative for creating regional networks and accountable care organizations ("ACOs").

- **Operational Leverage.** A strategic combination with a partner would provide substantial cost saving opportunities from operational expense rationalization and through the leveraging of information technology capabilities that could provide a positive impact on productivity and clinical quality.

- **Facility Upgrade.** Combining GWHN's existing long-term capital plans with an infusion of new capital can substantially increase profitability and top-line growth.

Leading Market Share Position

For several years, the Hospital has maintained the leading market share position in several key areas including obstetrics, behavioral health and musculoskeletal medicine. The Hospital's long-standing relationships with regional physicians and other hospitals have contributed to its overall success, making Waterbury Hospital and its subsidiaries and affiliates, referral sites for many services.

Exceptional Quality, Centers of Excellence and Other Accreditations

The Hospital and its affiliates have received multiple industry accolades for quality, excellent services and operations. Among the distinctions achieved:

- For the past two years, the Hospital was graded in the top 10% nationally by *Healthgrades* in Spinal Surgery
- For the past several years, the Hospital was graded in the top 5% nationally by *Healthgrades* in Orthopedic Joint Replacement
- Consumer Reports ranks Waterbury Hospital as #3 among the Ten Safest Hospitals in Connecticut (2012)

- U.S. News & World Report ranks Waterbury Hospital as #2 among the Best Hospitals in Connecticut (2012)
- Received the American Stroke Association's Get With the Guidelines – Stroke Gold Performance Achievement Award for consistently meeting the highest standards of care for stroke patients (2011)
- Received three-year accreditation by the American College of Surgeons/Commission on Cancer for its cancer program (2011)
- Ranked in the top ten percent in the nation for coronary intervention and received the 2010 Coronary Intervention Excellence Award
- Received accreditation recommendation by the American Society of System Pharmacists for its Pharmacy Residency Program (2010)

Strong Relationships and Partnerships

GWHN is known for its long-standing, meaningful partnerships with local hospitals and physicians for the overall health of the individual organizations and the communities it serves. This practice and philosophy has served GWHN and its partners well, strengthening the services available in Waterbury while enhancing services in regional locations.

Highlights include:

- Access Rehab Centers
- Greater Waterbury Imaging Center
- Harold Leever Regional Cancer Center
- Heart Center of Greater Waterbury

Attractive, but Competitive Market

Waterbury Hospital is located in Waterbury, Connecticut – the fifth largest city in Connecticut and ninth largest city in New England, with an estimated 2011 population of 110,189. The location of the Hospital is extremely advantageous in providing access via major transportation routes (Interstate 84 and Connecticut Route 8) and is visible from all around as it is located above city center.

Known as the "Brass City," the area once bustled as the home of the nation's only skilled brass craftsmen. But as the city developed, the brass industry left and a new, more modern and skilled labor force took hold. Industrial parks replaced the former brass mills and new businesses continue to relocate to the city. Today, service and retail trade industries are Waterbury's predominant players.

Waterbury's total population has remained fairly consistent in the past two decades, hovering near the 110,000 mark. Close to 80.0% of the population has at least a high school diploma, and almost half the population is in their prime earning years (25 – 55). Waterbury's unemployment is higher than the national trend.

For the past 100 years, Waterbury's health care needs have been served by two hospital systems, GWHN and SMH. While the two have attempted to merge all their operations three times in the past, (including this past year), the two institutions have been unable to successfully consummate a transaction. However, SMH and GWHN continue to work collaboratively on several initiatives, including the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury.

IV. Network and Hospital Overview

A. Network and Hospital Introduction

GWHN is a Connecticut non-stock, 501(c)(3) corporation consisting of four (4) active wholly-owned subsidiaries, the largest of which is The Waterbury Hospital**.** GWHN employs over 1,250 FTEs and is the second largest employer in Waterbury.

GWHN's mission is "To support and encourage the development of comprehensive, integrated, healthcare related services for the advancement of the health and well-being of the general public by providing financial, management and other assistance to its affiliates including Waterbury Hospital."

Waterbury Hospital, the first hospital in the city of Waterbury and fourth in the state of Connecticut, opened in 1890, after nearly a decade of fundraising. The original home was in a Victorian mansion overlooking the city. During its first twelve months of operation, 85 patients were admitted and two babies were born. The staff included eight physicians, ten nurses, one orderly, a janitor and a cook. Although there was hot and cold water, all operations were performed by daylight, since the light bulb had not yet been invented.

The Hospital, a wholly owned subsidiary of the Network, is a community teaching hospital located in the northern section of New Haven County, between Hartford and New York City. Its mission is "To provide compassionate, high quality health care services through a family of professionals and services." The Hospital is licensed for 357 beds and currently staffs approximately 190 beds excluding bassinets.

Table 4.1: Beds by Service Line

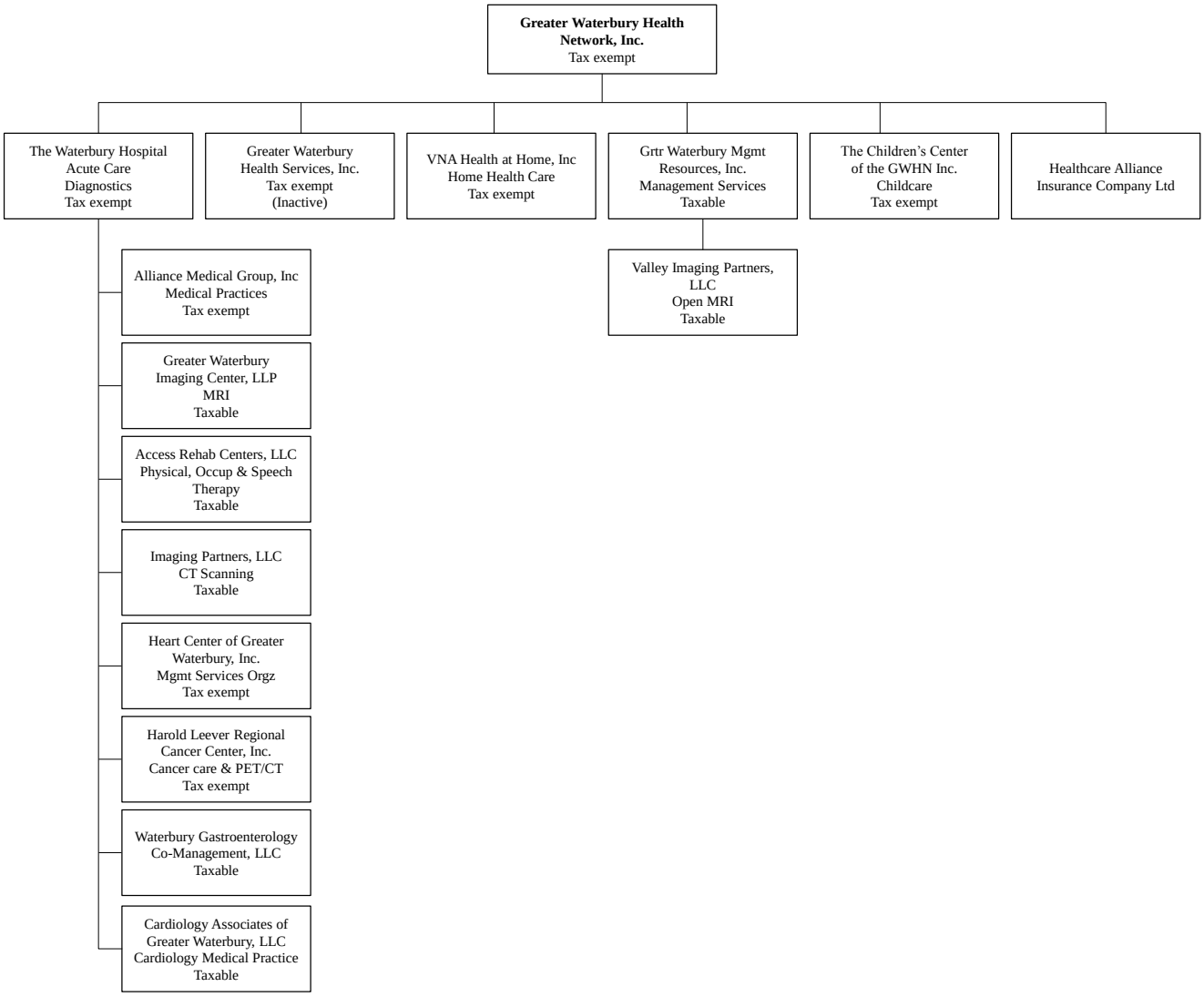
Service	Licensed Beds	Staffed Beds
Medical/Surgical	265	118
ICU / CCU	40	24
Psychiatry	30	30
Obstetrics	22	18
Sub-Total (Acute)	**357**	**190**

The Hospital is also a Connecticut non-stock corporation, exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code. A voluntary Board of Trustees elected by the Network governs the Hospital. The Hospital's Board of Trustees consists of individuals selected for their leadership and community interest who serve for a maximum of 12 years.

B. Affiliations and Partnerships

Set forth below is the organizational structure of the entities within the Company:

Table 4.2: Greater Waterbury Health Network



GHWN is the sole member or sole equity holder, as the case may be, of the following entities:

- **<u>The Waterbury Hospital (wholly-owned, 100%).</u>** The Hospital operates as an acute care teaching hospital under the direction of its Board of Trustees. (*Please see the following Section "C. Hospital Overview" for an overview of Hospital Services.)*

    - **<u>Alliance Medical Group Inc. (wholly-owned, 100%).</u>** Alliance Medical Group ("AMG") is a tax exempt 501(c)(3) medical foundation and a wholly owned subsidiary of the Hospital. AMG is the largest hospital-affiliated, multi-specialty group in the Waterbury area with more than 100 physicians and health care providers practicing in the following specialties: Internal

Medicine, Pediatric and Adolescent Medicine, Breast Surgery, General and Colorectal Surgery, Endocrinology, Pulmonary, Rheumatology, Infectious Disease/Travel Medicine and Sleep Medicine. AMG uses an electronic medical record ("EMR") system that allows all physicians access to their patients' medical records to streamline and coordinate care.

- **Greater Waterbury Imaging Center Limited Partnership (64% owner).** The Hospital is the general partner of Greater Waterbury Imaging Center Limited Partnership (the "Limited Partnership"), a Connecticut limited partnership formed to develop and operate a medical diagnostic imaging center. The Limited Partnership was formed in 1988. The imaging center, which is adjacent to the Hospital's Emergency Department, is in a building constructed by the Hospital and leased to the Limited Partnership. The Limited Partnership agreement does not commit the Hospital to fund any operational or capital deficits.

- **Access Rehab Centers LLC (65% owner).** Access Rehab Centers LLC ("Access") is a limited liability company formed in 1998 and owned by the Hospital and Easter Seal Rehabilitation of Greater Waterbury, Inc. It offers the region's largest and most comprehensive array of outpatient physical, occupational and speech therapy to adults and children. Access also provides physical therapy services on an inpatient basis to Waterbury Hospital. The two main facilities, located at 134 Grandview Avenue and 22 Tompkins Street, specialize in pain management, neurologic rehabilitation and therapies aimed at returning the patient to the work place. Access has nine additional outpatient locations serving the surrounding community.

- **Imaging Partners LLC (85% owner).** Imaging Partners LLC is a limited liability company owned by the Hospital and a private radiology practice, Diagnostic Radiology Associates, LLC. Formed in 2001, Imaging Partners offers advanced, multi-slice CT scanning services. Located at 134 Grandview Avenue in Waterbury in a convenient medical office building setting, this partnership is a key component of Waterbury Hospital's outpatient imaging network.

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

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

- **Greater Waterbury Health Services (wholly-owned, 100%).** Greater Waterbury Health Services, Inc., a not-for-profit corporation, was organized to provide for the contracting and management of tax-exempt community health services and programs in which GWHN may engage. Currently, there is no activity in this subsidiary.

- **VNA Health at Home (wholly-owned, 100%).** VNA Health at Home, Inc., ("VNA") is a non-profit, non-stock corporation established in 1939 and affiliated with the Company since 1996. VNA is a home health care agency that provides skilled nursing care, speech, physical and occupational therapy and medical social work throughout the Greater Waterbury region.

- **Greater Waterbury Management Resources (wholly-owned, 100%).** Greater Waterbury Management Resources, Inc. ("GWMRI"), of which the Network is the sole stockholder, is a taxable corporation. GWMRI is a Medical Service Organization originally organized to provide services to effectively manage medical group practices. While GWMRI has been in existence since 1984, there is minimal activity since the formation of and transition to AMG.

- **Children's Center (wholly-owned, 100%).** Children's Center of Greater Waterbury Health Network, Inc., ("CCGWHN") a not-for-profit tax exempt corporation, is a nationally accredited state-licensed childcare center. CCGWHN provides a staff of early childhood professionals to care for children from six weeks to five years of age and has been providing childcare services since 1997.

- **Healthcare Alliance Insurance Company (33% owner).** Healthcare Alliance Insurance Company, Ltd. ("HAIC") is a Cayman Islands based captive insurance company owned jointly by Griffin Health Services, Milford Health and Medical, Inc., and The Greater Waterbury Health Network, Inc. HAIC was created to offer professional malpractice and general liability insurance coverage to Griffin Hospital, Milford Hospital, and Waterbury Hospital, and members of their respective medical staffs. The Network became a shareholder in 2006 with 33% ownership.

  In addition to the above subsidiaries, the Hospital has two 50/50 Joint Ventures with Saint Mary's Hospital providing specialty services:

  - **Harold Leever Regional Cancer Center.** Harold Leever Regional Cancer Center, Inc. ("HLRCC"), a 501(c)(3) corporation, is a 50 / 50 JV between the Hospital and Saint Mary's. Formed in October 2002, HLRCC combined both hospitals' existing medical and radiation oncology businesses into one combined program to better meet the needs of the community. HLRCC provides state of the art cancer diagnostic and radiation services with two (2) linear accelerators and a PET/CT Scanner. Located at 1075 Chase Parkway, Waterbury, the building is also home to the area's two private medical oncology practices.

  - **Heart Center of Greater Waterbury.** Heart Center of Greater Waterbury ("HCGW"), a 501(c)(3) corporation, is a 50 / 50 JV between the Hospital and Saint Mary's. Under this joint program, the two hospitals are able to provide area residents with advanced cardiac services, including cardiac angioplasties and open heart surgery on both hospitals' campuses. The program performs over 650 angioplasties and 200 open heart surgeries annually.

C. Hospital Overview

Waterbury Hospital provides a variety of health care services including:

- **Orthopedic Services.** Waterbury Hospital, one of the busiest orthopedic centers in New England, receives high marks for outstanding clinical quality, performance and excellence in orthopedics, with special recognition for joint replacement surgery and spinal surgery. The Hospital's orthopedic surgeons specialize in providing diagnosis, treatment and rehabilitation for patients experiencing injury or disease of the bones, muscles, tendons, ligaments and nerves.
    - **The Joint Replacement Center.** The surgeons and staff at the Joint Replacement Center specialize in innovative surgical treatment for patients with knee and hip arthritis, treatment options and replacement options. The center performs more than 900 hip and knee replacements or revisions annually, making it one of the busiest orthopedic centers in the state.
    - **The Shoulder Center.** The Shoulder Center provides evaluation and management of shoulder injuries by experienced, fellowship-trained orthopedic surgeons. High-quality musculoskeletal radiologists, experienced OR teams, a full complement of advanced arthroscopic instrumentation and state-of-the-art rehabilitation combine to make the Hospital a regional leader in shoulder care
    - **Spine Care.** Waterbury Hospital provides care for individuals with a wide range of back and neck problems.
    - **Sports Orthopedics.** Sports Orthopedics uses the most advanced sports medicine and orthopedic practices, protocols and treatments to help patients return to sports. The physicians specialize on the hand, wrist, arm, elbow, foot and ankle.
- **Behavioral Health.** Behavioral Health of Waterbury Hospital employs a multidisciplinary approach and encourages the client to be an active participant in treatment. Through a blending of biologic and psychosocial modalities, the Hospital endeavors to reduce distress, to educate and to heal. The Hospital utilizes state-of-the-art therapies that assist patients in achieving their goals in a manner that preserves privacy and promotes personal dignity and hope. Whenever possible, the Hospital seeks to reduce the stigma associated with mental illness and to promote compassion and understanding.
    - **The Center for Behavioral Health.** Completed in 1997, The Center for Behavioral Health offers state-of-the-art treatment in a therapeutic environment. Located in the Pomeroy Pavilion at the Hospital, the Center for Behavioral Health features specialized units for the treatment of adolescents, adults and older individuals. The treatment team includes psychiatrists, psychologists, social workers, nurses, occupational therapists,

activity therapists and other mental health professionals working collaboratively with patients, families and providers.

- **Chemical Dependence & Dual-Diagnosis Services.** The program offers a range of options for people who have problems with alcohol, opiates, cocaine, cannabis, sedatives and other substances. The treatment team consists of nurses, substance abuse counselors and physicians. The multi-dimensional approach to chemical dependency incorporates medical, behavioral, motivational and harm-reduction strategies.

- **Child and Adolescent Services.** This partial hospital program provides daily intensive treatment in a structured environment. Treatment centers on the child/adolescent at risk and their families and other support systems. Therapies include group, individual and family, as well as other more specialized modalities such as anger management, creative expression, school issues forum, substance abuse treatment and separate male and female treatment groups. Multiple family meetings are offered in both the Partial Hospital Programs and Intensive Outpatient Programs. Intensive Outpatient Programs embrace a broad range of therapeutic techniques designed to assist children / adolescents and their families to work in an intensive and goal-focused manner.

- **Crisis Assessment and Triage Services.** The Crisis Assessment and Triage Service provide easy access to the entire continuum of behavioral health services at the Hospital. These services are available 24 hours per day, seven days per week. Appointments are available within 24 hours; however, clients may also be seen on an emergent/urgent basis.

- **The Comprehensive Center for Arthritis.** The Comprehensive Center for Arthritis specializes in the evaluation and treatment of patients with arthritis and other rheumatologic diseases. The physicians and staff provide diagnostic evaluations, ongoing care for patients with chronic rheumatologic problems and education to patients and their families. Patients also benefit from the physical, occupational and speech therapy services at Access Rehab Centers of Waterbury Hospital.

- **Emergency Services.** The Hospital is a Level II Trauma Center providing optimal care for all critically ill or injured patients.

- **The Family Birthing Center.** The Family Birthing Center offers 24 hour in-house obstetrics and anesthesia coverage by board certified physicians with years of experience. The Hospital's board certified neonatologists and CCMC mid-level practitioners are available to evaluate babies at birth. The neonatal intensive care unit ("NICU") is staffed with specially trained nurses and lactation counselors.

The NICU is a Level II nursery, which cares for babies at 28 weeks gestation and has relationships with tertiary centers if needed. The Family Birthing Center also provides Certified Nurse Midwife service allowing a low-intervention birth in a family-focused environment.

- **Henry S. Chase Outpatient Center.** The Henry S. Chase Outpatient Center offers general primary health care to individuals living in Greater Waterbury. Physicians, registered nurses and allied health professionals also provide orthopedic, surgical, urology, menopause, dermatology, gastroenterology, podiatry and musculoskeletal specialty services.

- **Hospitalist Program.** The Hospitalist Program provides patients with coordinated, seamless care during their stay at the Hospital. Hospitalists are licensed medical doctors, trained in internal medicine, who devote their practice to the unique needs of hospitalized patients. Hospitalists oversee a patient's care from admission to discharge. The hospitalists care for patients around-the-clock and work with private doctors to deliver the right care at the right time and are able to respond quickly and efficiently to changes in a patient's condition that may require a new medication, test or procedure.

- **Intensive Care / Telemetry.** A 20-bed Intensive Care unit and a 30-bed Telemetry unit combines a highly skilled nursing staff with the state-of-the-art technology necessary to meet the needs of patients. A centralized monitor watcher program maximizes the staff's ability to track patients closely. The units are an integral component of the Hospital's designation as a Level II Trauma Center.

- **Laboratory Services.** The Hospital operates nine blood drawing facilities in Waterbury, Middlebury, Naugatuck, Southbury, Thomaston, Watertown and Woodbury.

- **Medical Library.** The library is located on the first floor of the Hospital's North Wing and extends its services to patients, families, the community, and hospital-affiliated physicians, residents and students.

- **Medical Residency Program.** The Hospital is home to a robust medical residency program that is sponsored by the Yale School of Medicine and has the distinction of being the single, major community hospital training site for the Yale School of Medicine's Primary Care and Internal Medicine Residency Program. Since 1989, over 200 doctors have trained in the program. Since the program's inception, over 90 of these residents have continued to practice in Connecticut. Seven Alliance Medical Group primary care internists have trained in the Waterbury Hospital based program.

- **Outpatient Testing.** Outpatient Testing is located on the ground floor and provides testing including clinical laboratory testing, autologous donation services, EKG testing and preoperative assessments and instructions. It offers convenience by enabling patients to complete their testing needs in one convenient location.

- **Pharmacy Program.** The Hospital offers a PGY-1 clinical Pharmacy Residency Program and is accredited by the American Society of Health-System Pharmacists ("ASHP") with two resident positions available each year. The Hospital also participates in the Resident Match Program.

- **Reed Cardiology.** The Reed Cardiology Department provides cardiac and pulmonary patients with exceptional, individualized medical services from diagnostic to rehabilitation. The staff consists of cardiologists, registered and practices nurses, nurses, physical and respiratory therapists and technicians, invasive and non-invasive cardiopulmonary technicians, exercise specialists, as well as registered echocardiography, nuclear medicine and EKG technicians**.**

    - **Invasive Cardiac Testing and Intervention.** Services include cardiac catheterization and coronary angioplasty/stent.

    - **Non-Invasive Heart Testing.** Services include echocardiogram, trans-esophageal echocardiogram, treadmill stress testing, nuclear stress testing, pulmonary function test, exercise physiology test, holter monitory and pacemaker clinic.

    - **Cardiopulmonary Rehabilitation.** Twenty-four hour patient monitoring and extensive wellness and rehabilitation services for cardiac and pulmonary patients are also offered. Services include inpatient cardiac rehabilitation (phase I), outpatient cardiac rehabilitation (phase II), cardiac rehabilitation (phase III), Volunteer Visitation Program and Healthy Hearts Club.

- **The Reed Surgery Center.** The Reed Surgery Center ("Reed") is equipped with the latest surgical instrumentation, including minimally-invasive technology. There are approximately 6,000 out-patient surgeries a year at the Hospital. One Day Surgery routinely handles general, gynecological, and orthopedic procedures, as well as all non-surgical procedures and post-operative care, including liver biopsy, cardioversion, anesthesia procedures, bronchoscopy, arteriogram preparation and recovery, cardiac catheterization recovery and MRI and CT-Scan sedation.

- **Sleep Lab.** The facility is dedicated to sleep disorders through sleep consultations and customized treatments. More than 30 percent of individuals suffer from a sleep-related problem which may include severe snoring sleep apnea, restless legs syndrome, narcolepsy and insomnia. Sleep disorders can result in a wide range of problems including worsening of depression, high blood pressure, ADHD in all ages and increased risk of coronary artery disease. The Sleep Lab has one off campus location in Middlebury.

- **Surgical Residency Program.** The Hospital's surgical residency program is one of the few remaining independent surgical residency programs in the country, providing a full spectrum of surgical experiences for its trainees. The Hospital's residents have access to general surgery, ENT, urology, plastics, GYN, neurosurgery and orthopedic cases. As a Level II Trauma facility, they also receive education and experience in the trauma specialty. The Surgical Residency Program also trains medical students from the University of Connecticut School of Medicine and PA students from Quinnipiac University. The residents rotate at Yale New Haven Hospital, Hartford Hospital and Connecticut Children's Medical Center. Over 60 years old, the surgical residency program has graduated over 120 surgeons, many of whom have accepted prestigious fellowship appointments at prominent hospitals across the country. Four of the five surgeons in Alliance Medical Group have trained in the Waterbury Hospital based program.

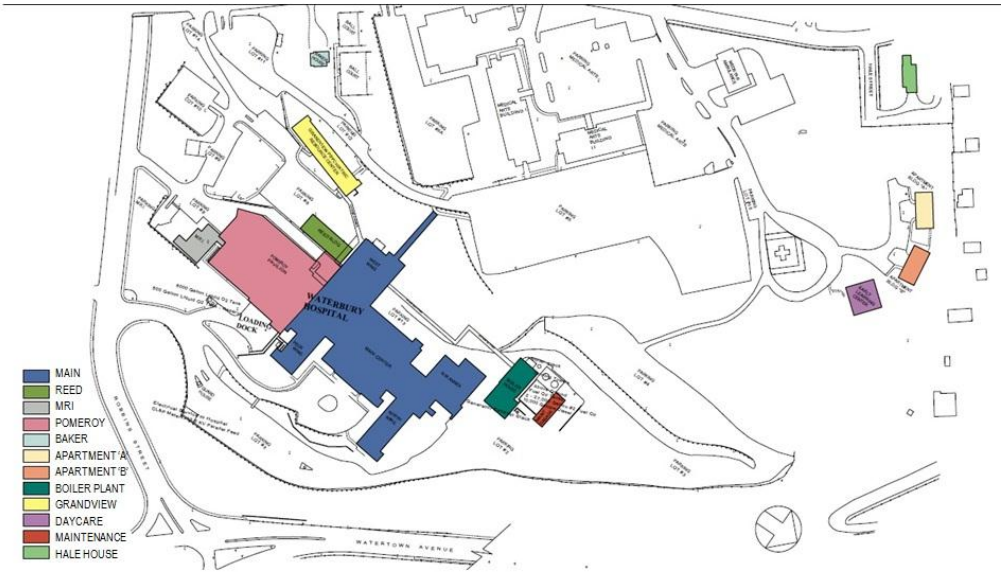
  The Stroke Center. The Hospital is certified by the Connecticut Department of Public Health as a Primary Stroke Center. Waterbury Hospital provides the very latest and best treatment options for stroke victims. The Stroke Center team treats patients who have had strokes and TIAs (transient

ischemic attacks) by providing emergency stroke treatment, as well as education for hospital inpatients and the community on stroke risk factors and warning signs, stroke prevention and rehabilitation.

D. Facilities

The Hospital campus is located on 38 acres in the west side of Waterbury at the cross roads of Route 8 and Interstate 84. The lower campus, accessed from Robbins Street, is home to the main hospital facilities, including inpatient, outpatient and emergency services. The Pomeroy Pavilion houses all of the inpatient services. The Reed Surgical Center is a state of the operating suite where advanced cardiac surgery is performed. The upper campus, accessed from Grandview Avenue, offers a suite of Medical Offices as well as the Children's Center and helipad. Also accessed from Grandview Avenue is the outpatient Behavioral Health Services. The Development Office sits adjacent to the upper campus.

Table 4.3: Waterbury Hospital Facility Map



The Hospital consists of 12 floors, with additional lower and ground levels. The following tables are representative floor plans of several of the floors:

Table 4.4: Waterbury Hospital Facility Map – Lower Level

Table 4.5: Waterbury Hospital Facility Map – Ground Floor

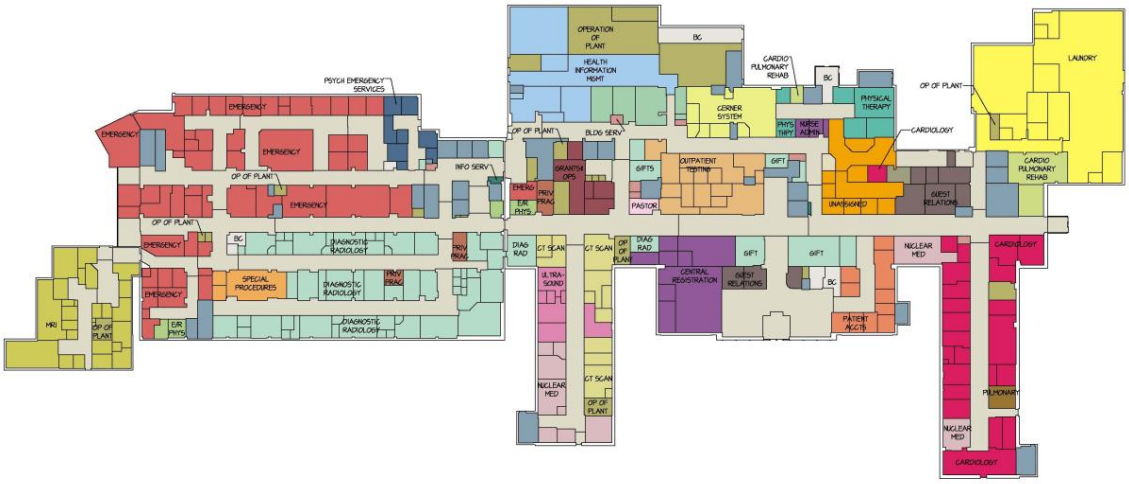


Table 4.6: Waterbury Hospital Facility Map – First Floor

Table 4.7: Waterbury Hospital Facility Map – Second Floor

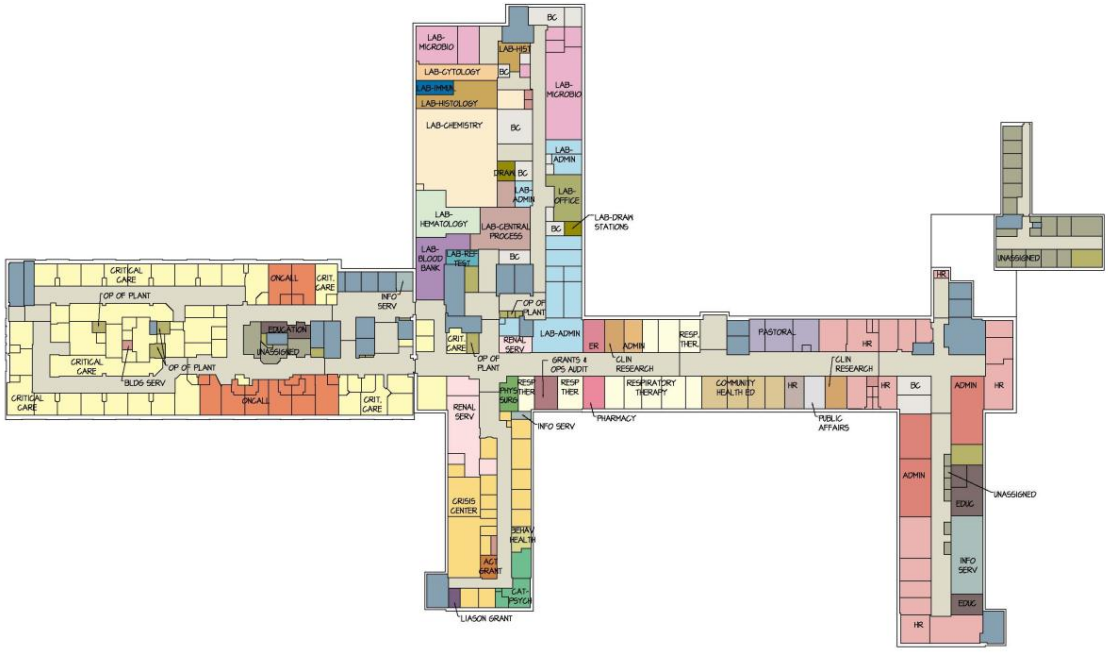


Table 4.8: Waterbury Hospital Facility Map – Third Floor

Table 4.9: Waterbury Hospital Facility Map – Fourth Floor

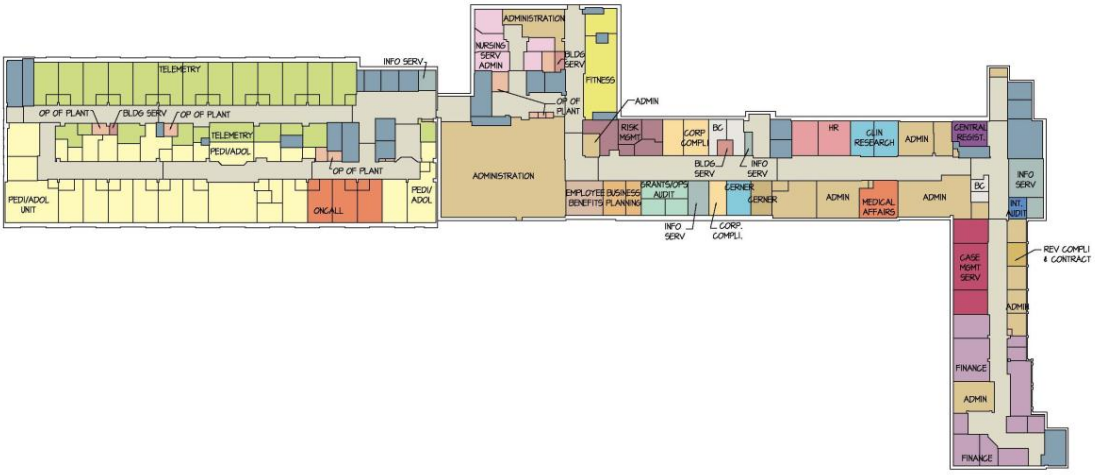


Table 4.10: Waterbury Hospital Facility Map – Fifth Floor

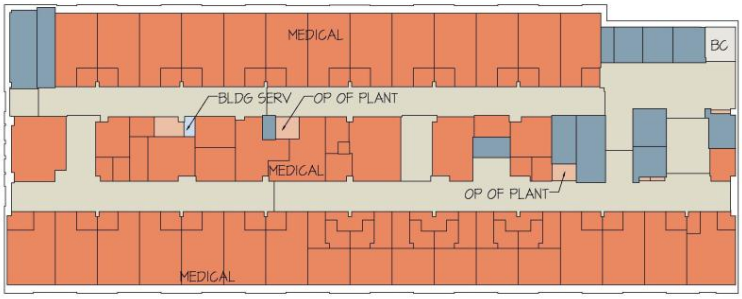


Table 4.11: Waterbury Hospital Facility Map – Sixth Floor

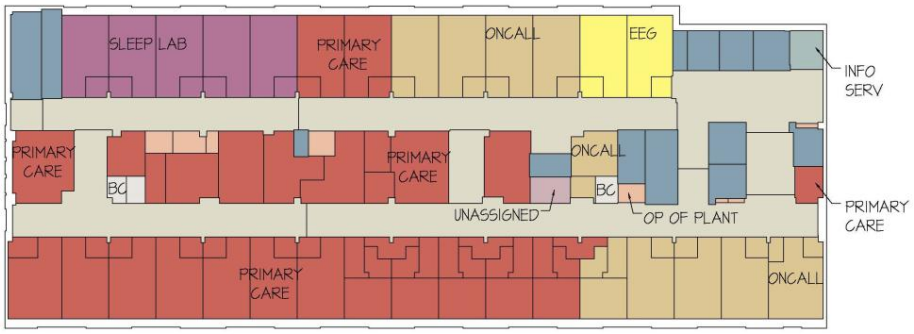


Table 4.12: Waterbury Hospital Facility Map – Seventh Floor

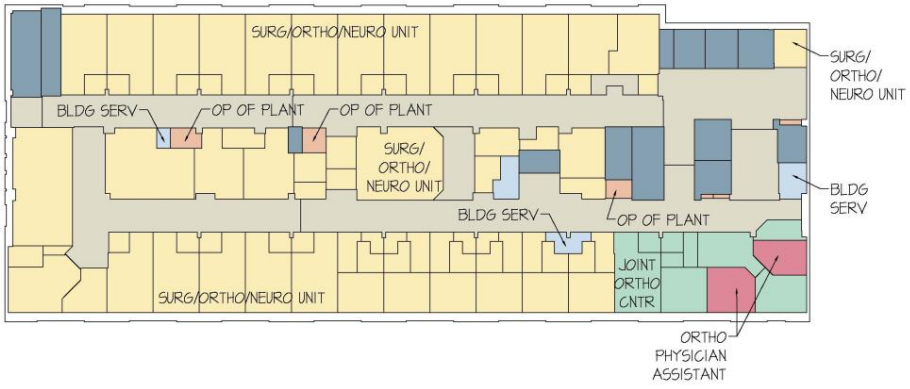


Table 4.13: Waterbury Hospital Facility Map – Eighth Floor

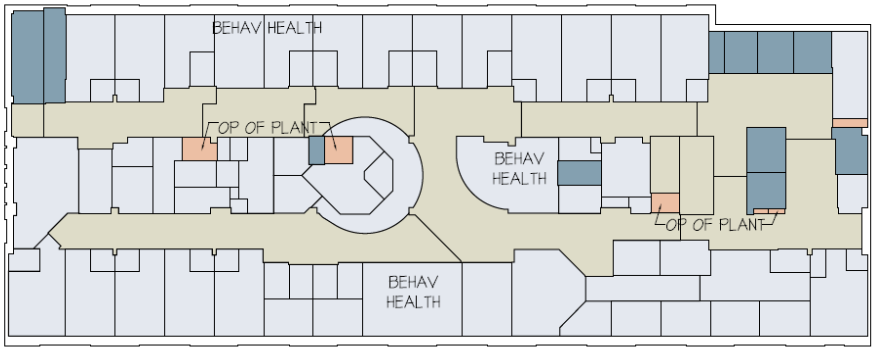


Table 4.14: Waterbury Hospital Facility Map – Ninth Floor

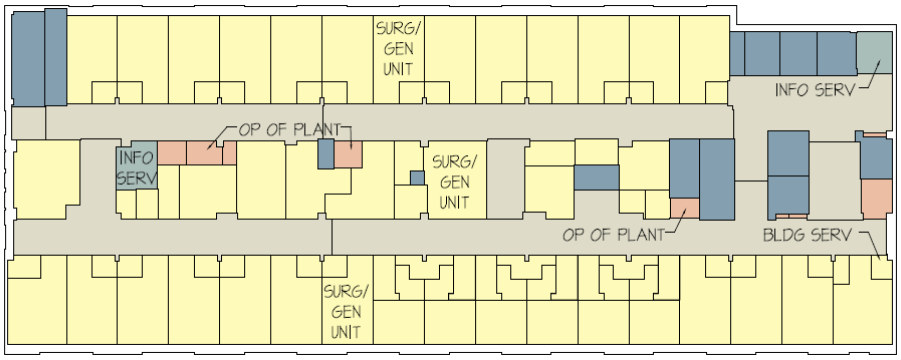
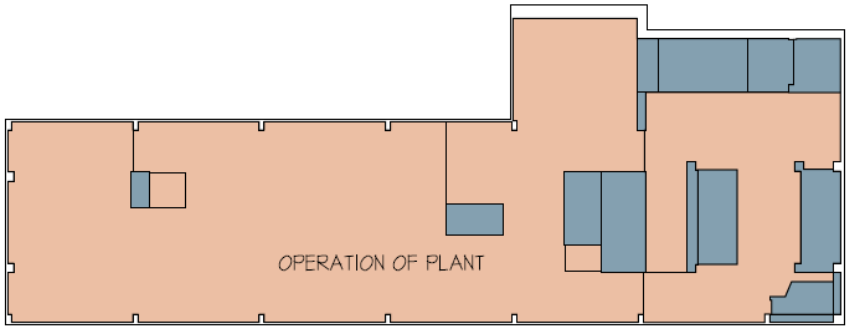


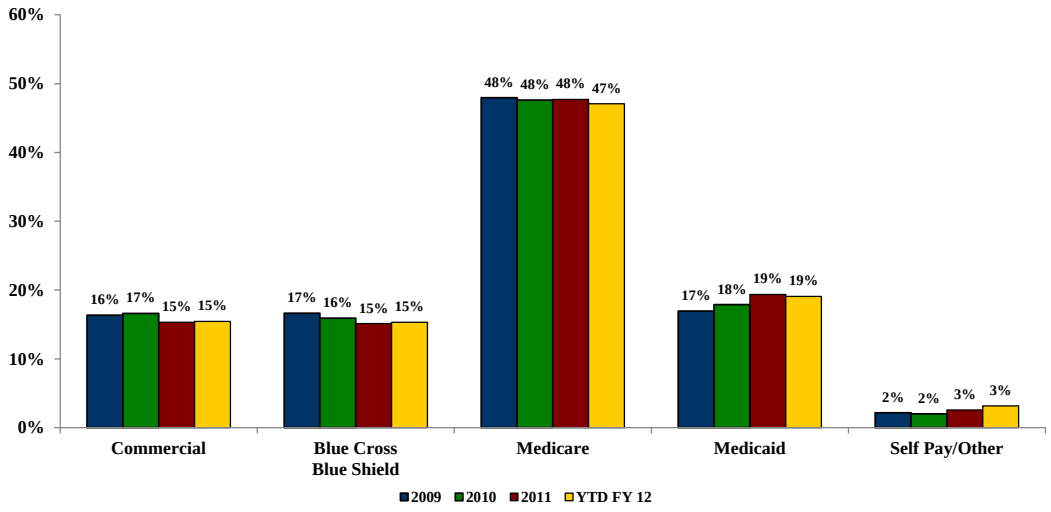
Table 4.15: Waterbury Hospital Facility Map – Tenth Floor



E. Payor Mix

The Hospital's payor mix has remained relatively steady since 2007. The Hospital's historical payor mix is as follows:

Table 4.16: Waterbury Hospital Historical Payor Mix (by Gross Revenue)



Note: Fiscal year ends September 30

The Hospital's payors are comprised primarily of Commercial, Blue Cross Blue Shield and government payors including Medicare and Medicaid.

- **Commercial.** The Hospital has contracts with PPO and/or PPO/HMO/POS managed care organizations that account for about 15% of the Hospital's payor mix.

- **Blue Cross Blue Shield.** The Hospital contracts with Anthem Blue Cross Blue Shield, which comprises about 15% of the Hospital's payor mix.

- **Medicare.** The Hospital's Medicare revenues are generated through both traditional and Medicare Advantage programs. Medicare comprises about 47% of the Hospital's payor mix. As the population continues to age, the Hospital expects to see a continuing increase in Medicare's portion of the payor mix, along with a corresponding increase in the losses associated with the provision of this care.

- **Medicaid.** The Hospital's Medicaid revenues are derived from Aetna Better Health, AmeriChoice, CHN, State Medicaid and Medicaid LIA. Overall, Medicaid comprises about 19% of the Hospital's payor mix.

- **Self Pay/Other.** The uninsured patient population and other payors comprise about three percent of the Hospital's payor mix.

F. Utilization Statistics

The Hospital's historical utilization statistics are as follows:

Table 4.17: Waterbury Hospital Only Utilization Statistics

	2009	2010	2011	For the 10 Months Ended July 31, 2012
Inpatient Admissions				
Adults & Children	12,707	11,921	11,634	9,312
Newborns	1,221	1,125	1,124	939
Total	13,928	13,046	12,758	10,251
Patient Days				
Adults & Children	63,850	55,788	55,209	45,258
Newborns	3,832	3,483	3,571	2,982
Total	67,682	59,271	58,780	48,240
Average Length of Stay (days)				
Adults & Children	5.02	4.68	4.75	4.86
Newborns	3.14	3.10	3.18	3.18
Average	4.86	4.54	4.61	4.71
Daily Patient Census				
Adults & Children	175	153	151	149
Newborns	10	10	10	10
Total	185	162	161	159
Percent of Occupancy (Based on staffed beds)	96.08%	85.79%	84.76%	97.75%
Ambulatory Surgery Cases	4,513	4,504	4,644	4,081
Emergency Department Visits (Inpatient and Outpatient)	58,561	58,443	57,816	47,180
Patient Care Services				
CT Scans	22,435	21,253	17,829	12,996
Drug Orders Dispensed	1,876,529	1,474,965	1,442,901	1,417,420
EEG Exams	2,510	2,193	1,759	1,554
EKG Exams	30,350	29,466	30,975	25,154
Laboratory tests	1,168,999	1,090,040	1,114,691	947,411
Meals served to patients	170,918	167,364	165,627	135,774
Nuclear medicine treatments (contains drugs)	12,719	9,098	8,949	6,552
Psychiatric visits	29,060	27,272	27,297	24,065
Pulmonary disease treatments	83,186	73,746	71,887	60,202
Surgical operations	8,680	7,776	7,517	6,228
Ultrasound exams	8,996	9,267	9,128	7,207
X-ray exams	52,250	48,358	46,298	36,134

Note: Fiscal year ends September 30

G. Procedure Mix

The Hospital provides a wide breadth of services to the community. Its procedure mix is as follows:

Table 4.18: Waterbury Hospital Only Historical Procedure Mix – Inpatient Cases

	2009	2010	2011	For the 10 Months Ended July 31, 2012
Medical*	5,332	4,941	4,963	4,044
Medical Cardiology	1,517	1,340	1,408	1,149
Newborn	1,230	1,129	1,126	940
Maternity	1,202	1,114	1,109	925
Mental Disease/Substance Abuse	794	916	860	790
Surgical	1,074	960	947	692
Major Joint	958	963	724	499
Ortho	423	404	384	305
Angioplasty	334	339	366	223
Surgical Cardiology	277	249	207	179
Neurosurgery	145	135	152	157
Ortho Nonsurgical	161	142	154	118
Urology	228	180	178	145
Gynecology	253	234	176	85
Total Cases	**13,928**	**13,046**	**12,754**	**10,251**

Source: Company Reports
Note: Fiscal year ends September 30
**Includes pediatric inpatient cases*

Table 4.19: Waterbury Hospital Only Historical Contribution Margin – Inpatient Cases

	2009	2010	2011	For the 10 Months Ended July 31, 2012
Surgical Cardiology	$7,466	$5,422	$5,193	$6,986
Major Joint	5,484	7,513	7,066	6,269
Ortho	4,288	7,187	3,617	6,055
Surgical	6,350	7,502	5,960	5,760
Neurosurgery	7,367	6,539	8,739	5,691
Medical*	4,179	4,473	3,843	3,795
Angioplasty	6,232	4,309	2,739	3,623
Medical Cardiology	3,709	3,830	2,926	2,911
Mental Disease/Substance Abuse	2,097	2,112	1,816	2,732
Ortho Nonsurgical	2,437	3,338	3,928	2,657
Urology	4,144	3,848	3,642	2,468
Newborn	1,600	878	913	1,423
Gynecology	1,419	1,669	1,365	910
Maternity	1,335	262	981	704
Inpatient Contribution Margin / Case	**$3,873**	**$4,066**	**$3,396**	**$3,463**

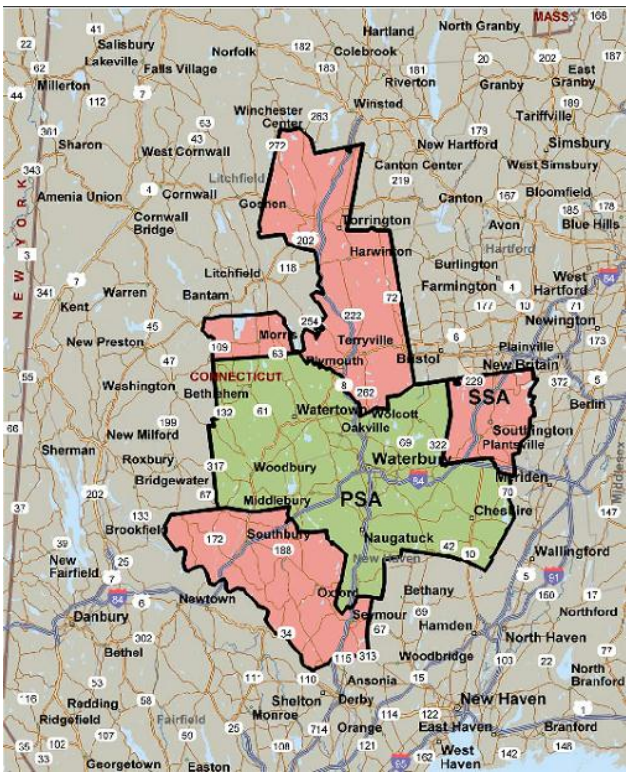
Source: Company Reports
Note: Fiscal year ends September 30
**Includes pediatric inpatient cases*

V. Service Area Profile

The Hospital's primary service area, with a total population of approximately 270,000, includes eight towns in New Haven County: Beacon Falls, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Waterbury and Wolcott and four towns in Litchfield County: Bethlehem, Thomaston, Watertown/Oakville and Woodbury. 90 percent of Waterbury Hospital in-patients live within the primary market. Residents of the City of Waterbury account for approximately 46% of all inpatient discharges.

The secondary service area includes six towns: Morris, Oxford, Plymouth/Terryville, Seymour, Southington/Plantsville and Torrington.

Table 5.1: Waterbury Hospital Service Area Map



A. Demographics

The Hospital is located in the City of Waterbury, the fifth largest city in Connecticut. The City of Waterbury has approximately 110,000 residents, with the gender breakdown approximately an even split (53.0% female / 47.0% male). The City is also relatively young with a median age of 34.7 years.

According to the American Community Survey 2006-2010, the racial breakdown of the City of Waterbury is predominantly white/Caucasian, with a large minority of African Americans and small minority of Asians. The median household income of the Waterbury is approximately $40,000. The most recent unemployment rate of Waterbury was higher than the national trend, at 12.1%.

Table 5.2: Market Demographics

	City of Waterbury	
Male	51,341	46.7%
Female	58,600	53.3%
Total Population	109,941	100.0%
Age		
0-19 years	32,551	29.6%
20-54 years	52,039	47.3%
55-84 years	22,393	20.4%
85+ years	2,958	2.7%
Median Age	34.7	
Race		
White alone	66,179	60.2%
Black or African American alone	20,771	18.9%
Asian alone	2,051	1.9%
Two or more races	6,071	5.5%
Other	14,869	13.5%
Median Household Income	$40,254	
Mean Household Income	$52,432	
High school degree or higher	78.5%	
Unemployment rate	12.1%	
Industry of Employed over 16 Years of Age		
Agriculture, forestry, fishing and hunting and mining	84	0.2%
Construction	2,836	6.0%
Manufacturing	6,927	14.7%
Wholesale trade	982	2.1%
Retail trade	6,286	13.3%
Transportation and warehousing and utilities	2,134	4.5%
Information	1,018	2.2%
Finance and insurance, real estate, rental and leasing	2,740	5.8%
Professional, scientific, and management and administrative & waste management services	2,885	6.1%
Educational services and health care & social assistance	13,177	28.0%
Arts, entertainment, recreation, accommodation and food services	3,738	7.9%
Other services, except public administration	2,007	4.3%
Public administration	2,293	4.9%
Total	47,107	100.0%

Source: U.S. Census Bureau, 2006-2010 American Community Survey

B. Competition

Waterbury Hospital has maintained a strong market position in its Primary Service Area driven by its community reputation as a quality service provider.

Table 5.3: Competitive Landscape

		Distance from WH	Staffed Beds	Admissions	Census	Outpatient Visits	Births
1)	Waterbury Hospital	–	190	12,758	161	199,978	1,124
2)	Saint Mary's Hospital	1	181	11,198	138	233,332	1,082
3)	Bristol Hospital	10	115	NA	NA	NA	NA
4)	MidState Medical Center	13	130	8,873	110	158,405	945
5)	Griffin Hospital	16	111	7,109	87	186,418	611
6)	The Hospital of Central Connecticut	16	263	17,763	208	325,106	1,760
7)	The Charlotte Hungerford Hospital	17	105	NA	NA	NA	NA
8)	Hospital of Saint Raphael	18	406	NA	NA	NA	NA
9)	New Milford Hospital	18	62	2,251	24	114,236	261
10)	Yale-New Haven Hospital	19	959	52,302	712	413,090	4,318
11)	Veterans Affairs Connecticut Healthcare System	20	200	NA	NA	NA	NA
12)	Middlesex Hospital	21	209	12,767	150	1,370,876	1,151
13)	Danbury Hospital	23	325	18,754	247	384,655	2,164
14)	Connecticut Children's Medical Center	24	147	6,753	101	145,134	NA
15)	Hartford Hospital	24	601	37,404	576	202,847	3,792
16)	Milford Hospital	24	87	NA	NA	NA	NA
17)	Saint Francis Hospital and Medical Center	24	566	28,881	406	311,953	2,771
18)	Bridgeport Hospital	26	373	16,955	273	250,040	2,163
19)	St. Vincent's Medical Center	26	376	20,689	326	226,617	1,152

Source: American Hospital Association Guide 2011

The Hospital's primary competitors are considered:

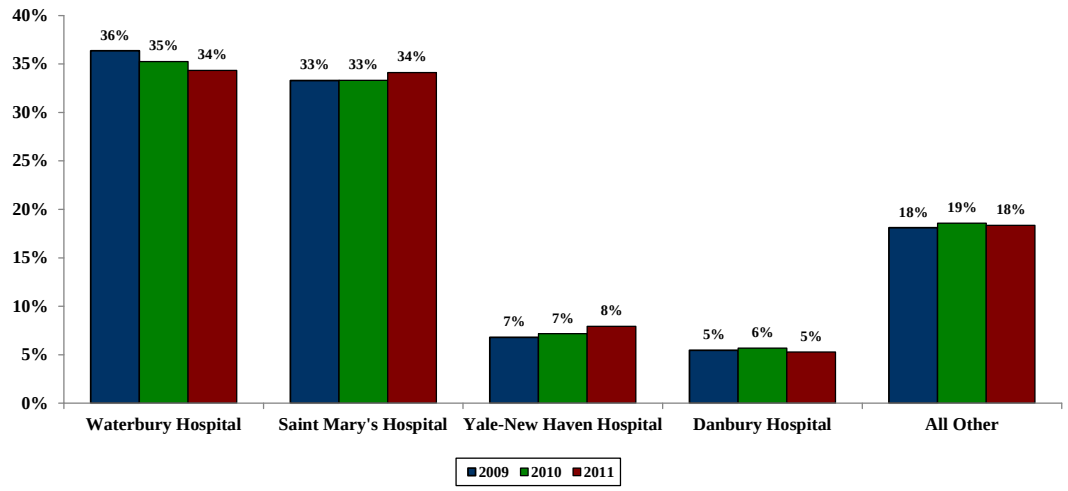
Saint Mary's Hospital – located one mile away from the Hospital, Saint Mary's is an acute care community teaching hospital that has served Greater Waterbury for more than 100 years. Licensed for 347 beds, Saint Mary's has designated Level II Trauma Center and Primary Stroke Center, and offers several acute care services including cardiac, pediatric emergency and surgical services.

Yale-New Haven Hospital – located 19 miles south of the Hospital, Yale-New Haven is a 966-bed, not-for-profit hospital serving as the primary teaching hospital for the Yale School of Medicine. The Yale-New Haven Hospital complex includes Yale-New Haven Children's Hospital, Yale-New Haven Psychiatric Hospital and Smilow Cancer Hospital at Yale-New Haven. Yale-New Haven has a combined medical staff of about 2,200 university and community physicians practicing in more than 100 specialties. The Yale-New Haven Health System consists of Yale-New Haven Hospital and its affiliates, Bridgeport Hospital and Greenwich Hospital. In September 2012, Yale-New Haven Hospital acquired the Hospital of Saint Raphael, a 511-bed community teaching hospital also in New Haven.

Danbury Hospital – located 23 miles west of the Hospital is a 371-bed regional medical center and university teaching hospital associated with Yale University School of Medicine, the University Of Connecticut School Of Medicine, and the University of Vermont. On October 1, 2010, Danbury Hospital and New Milford Hospital affiliated into "Western Connecticut Healthcare Network" and announced in early 2012 that it was exploring a partnership with Norwalk Hospital.

The Hospital has a strong market position in its PSA with 34% of the total PSA volume.

Table 5.4: Top 5 Primary Service Area Competitors



Source: Company Reports
Note: Fiscal year ends September 30

VI. Organization and Management

A. Organizational Structure and Employees

As of August 31, 2012, the Hospital had a total full time employee count of 1,265.69 FTEs. The following is the Hospital's FTEs by department:

Table 6.1: Waterbury Hospital Only Full Time Employees

(as of August 31, 2012)

Department	FTEs Assigned	Department	FTEs Assigned
Administration	5.07	Lab - Office Staff	4.48
Administrative Finance	0.63	Lab - Shift 2	8.80
Adolescent PHP & IOP	6.80	Lab - Shift 3	4.51
American Savings Foundation	0.09	Main PACU	9.58
ATT Adult Outpatient	2.81	Medical Affairs	2.00
Bed Control	3.48	Medical Library	1.60
Behavioral Health Consults	0.98	Medical Staff Office	1.01
Cardiac Diagnostic Center	17.26	Medical Unit	49.46
Cardiac Unit	21.76	Middlebury X-Ray	1.48
Cardio Pulmonary Rehab	3.03	Nuclear Medicine	2.51
Cardiology	16.26	Nursing Service Admin	10.70
Case Management	17.04	Operating Room	48.11
Center for Behav Health	57.02	OR Administration	4.91
Central Registration	30.99	Outpatient Med Therapy	5.55
Central Sterile Processing	15.23	Outpatient Testing	3.70
Children's Behav Health	3.88	P6 Med/Surg	33.49
Clinical Chemistry	10.92	Parent Trust Grant	0.63
Clinical Engineering	6.91	Partial Hospital Day Program	1.23
Crisis Center	12.97	Patient Accts/Finl Srvs	19.73
Critical Care Unit	39.51	Performance Improvement	4.71
CT Scan	9.01	Perinatology	0.80
CVU,Int Care & Tele Float Pool	1.77	Pharmacy	34.84
DBTIOP Grant	2.81	Plant Engineering	18.17
Development	1.04	Pre-Operating	15.49
Diagnostic Radiology	24.20	Primary Care	45.25
Disability Services	6.67	Private Fdn Grants	3.66
Disaster Preparedness	0.14	Psych Addiction Services	12.02
DMHAS Outpatient Grant	2.17	Psych Admin	1.26
DPH-WHAP State Approp Fd	6.91	Psych Assess & Triage	3.92
Education & Org Dev	5.01	Psych Emergency Srvs BHED	10.40
EEG	1.23	Psych O/P Services	12.27
Emergency Department	81.85	Public Affairs	2.00
Employee Benefits	0.23	Pulmonary Function	0.41
Family Birthing Center	43.49	Purchasing	6.02
FBC Admin	1.53	Radiology Special Procedures	6.24
Finance	11.54	Reed PACU	11.26
Floats	11.72	Respiratory Therapy	18.09
Gastroenterology	10.90	Respite Grant	0.38
Geriatric IOP & Outpt	4.87	Risk Management	2.00
Grants & Operations Audit	1.75	RW Yale SPNS	3.29
Health Information Mgmt	30.41	Ryan White I Grant	0.98
Human Resources	10.17	Ryan White III Grant	2.02
I/P Psych DHMAS Grant	0.12	Ryan White Part C Sup Fd	0.01
Information Services	32.32	Safety/Security	22.51
Interns & Residents	14.19	Shelter Grant	1.65
Konica, Clinical Trials	0.50	Sleep Lab	5.93
Lab - Administration	1.99	Special Care Nursery	11.66
Lab - Blood Bank	5.62	Storeroom/Receiving	5.81
Lab - Central Process	7.83	Surg/Gen Unit	51.86
Lab - Cytology	1.26	Surg/Ortho/Neuro Unit	34.91
Lab - Draw Stations	15.96	Telemetry	55.88
Lab - Hematology	4.89	Trauma Program	1.26
Lab - Histology	3.40	Ultrasound	4.98
Lab - House Calls	0.88	Yale New Hope	0.76
Lab - Microbiology	8.49	**Total FTEs**	**1,265.69**

The Hospital has a diverse medical staff with a total active medical staff of 362 physicians, comprised of physicians and dentists categorized within 30 specialty areas. Management believes there is a significant opportunity for a strategic partner to provide additional resources and enhance physician recruitment efforts.

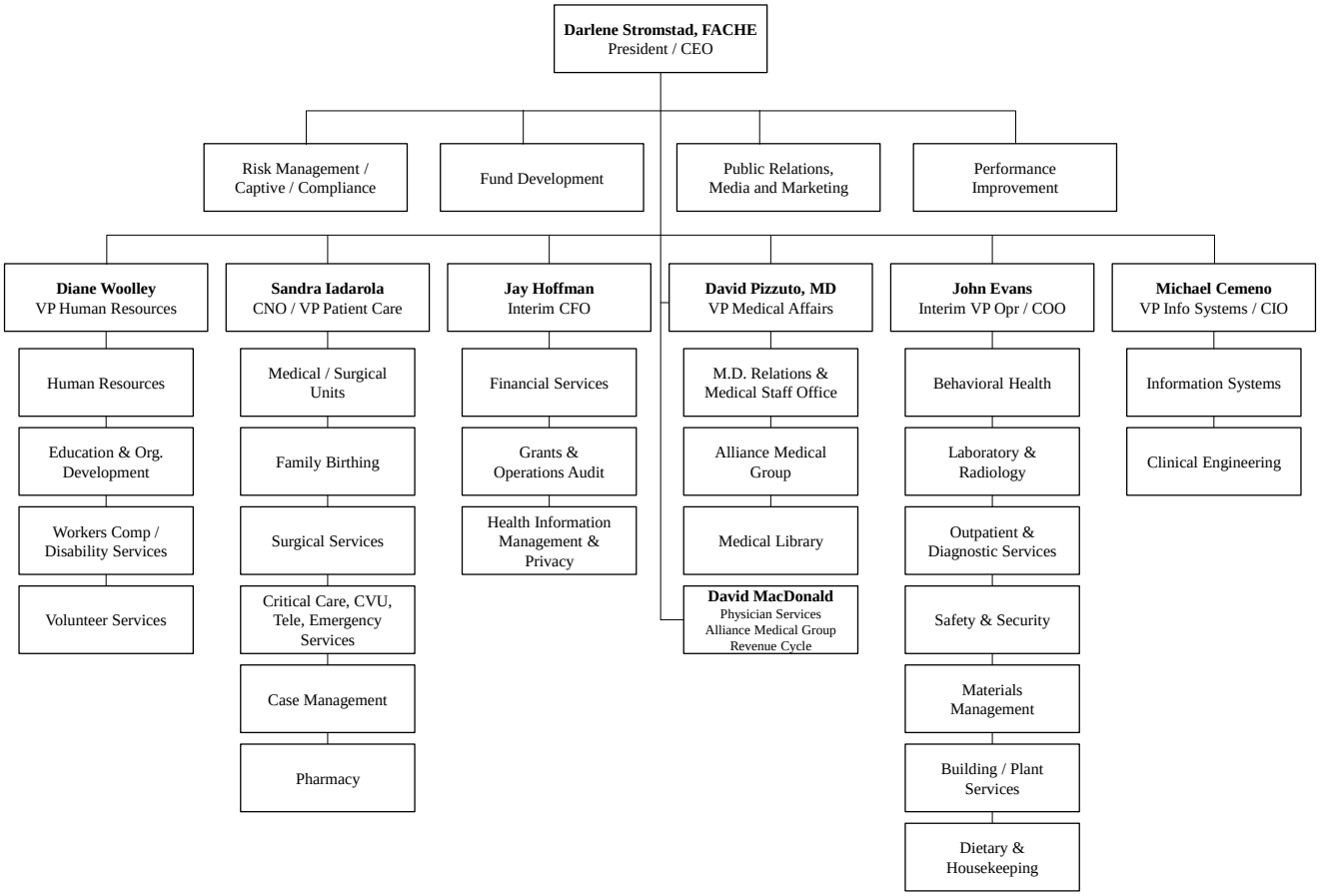
Table 6.2: Physician Staff

(as of September 10, 2012)

Clinical Services	Number of Total Attending Physicians	Average Age	Board Certified	
			Number	Percent
MEDICINE:				
General Medicine	82	45	82	100%
Cardiology	18	52	18	100%
Gastroenterology	9	58	9	100%
Oncology	5	50	5	100%
Neurology	5	47	5	100%
Pulmonary	9	52	9	100%
Dermatology	1	35	1	100%
Endocrinology	3	50	3	100%
Infectious Disease	5	40	5	100%
Nephrology	11	52	11	100%
SURGERY:				
General Surgery	12	55	12	100%
Ophthalmology	12	53	11	92%
Orthopedics	18	52	17	94%
Otolaryngology	7	55	7	100%
Urology	7	51	7	100%
Neurosurgery	5	51	5	100%
Plastic Surgery	5	56	5	100%
Oral Surgery	1	56	1	100%
Vascular Surgery	6	43	6	100%
Podiatry	16	53	16	100%
Thoracic Surgery	4	55	4	100%
PEDIATRICS	34	53	34	100%
OB/GYN	22	50	22	100%
PSYCHIATRY	11	61	11	100%
OTHER:				
Anesthesiology	16	53	16	100%
Pathology	3	47	3	100%
Radiology	9	55	9	100%
Emergency Medicine	20	43	20	100%
Rheumatology	3	51	3	100%
Physical Medicine	3	38	3	100%
TOTAL	362	50	360	99%

The table below sets forth Waterbury Hospital's corporate organization structure:

Table 6.3: Waterbury Hospital Management Organization



B. Collective Bargaining Units

Nursing, service and maintenance employees are represented by unions. Registered nurses and licensed practical nurses are represented by the Connecticut Health Care Associates, National Union of Hospital and Health Care Employees, AFSCME, AFL-CIO. The collective bargaining contracts for these unions are in effect until September 2013. The service and maintenance department is represented by the New England Health Care Employees Union, District 1199, SEIU/AFL-CIO. Its contract has expired; negotiations are underway.

Table 6.4: FTEs by Union

	FTEs
CHCA Union FTEs	352.97
1199 Union FTEs	183.38
Non-Union FTEs	729.34
Total	1,265.69

C. Executive Leadership Team Biographies

The responsibility for day-to-day operations and implementation of the Board of Trustees policies rests with Management. The Management team is led by:

Table 6.5: Waterbury Hospital Management Team

Name	Title	Age	Years with Waterbury Hospital
Darlene Stromstad, FACHE	President and CEO	56	1
David Pizzuto, MD	VP of Medical Affairs and Chief Medical Officer	57	24
Sandra Iadarola, RN	Chief Nursing Officer, VP of Patient Care	60	10
Diane Woolley	VP of Human Resources	45	5
Michael Cemeno	VP of Information Services	56	2
David MacDonald	Interim VP of Physician Services	42	1
Jay Hoffman	Interim VP of Finance	59	0
John Evans, FACHE	Interim VP of COO	57	1

Darlene Stromstad, FACHE, President and Chief Executive Officer. Ms. Stromstad joined the Hospital in July 2011 as its new President and Chief Executive Officer. Prior to coming to the Hospital, Ms. Stromstad served as President and Chief Executive Officer of Goodall Hospital and its community affiliates in Sanford, Maine for six years. Prior to becoming CEO of Goodall Hospital in 2005, she held the positions of Senior Vice President at Catholic Medical Center from 1999 to 2004, Senior Vice President at Olympus Healthcare from 1997 to 1999, and Vice President at St. Joseph Healthcare from 1988 to 1996. Ms. Stromstad holds an MBA from Rivier College and a Bachelor of Arts degree from the University of North Dakota. Ms. Stromstad is a Fellow and Member of the Board of Governors for the American College of Healthcare Executives.

David Pizzuto, MD, Vice President of Medical Affairs and Chief Medical Officer. Dr. Pizzuto became the Vice President of Medical Affairs/CMO in June 2011. A graduate of The Waterbury Hospital Internal Medicine Residency Program, he has been a member of the Attending Medical Staff for 24 years. In addition to his administrative duties, Dr. Pizzuto also continues to practice Internal Medicine full time. Dr. Pizzuto has held various leadership roles at Waterbury Hospital including Chairman of the Department of Medicine, Chief of Staff, and member of the Board of Trustees. Dr. Pizzuto holds an M.D. from New York Medical College, a Master of Science from the University of Minnesota, and a Bachelor of Science from the University of Connecticut. He is certified by the American Board of Internal Medicine.

Sandra Iadarola, RN, Chief Nursing Officer and Vice President of Patient Care. Ms. Iadarola joined the Hospital in March 2002 and served as the Administrative Director of Medical/Surgical and Critical Care Services until assuming the Chief Nursing Officer role in February 2011. Prior to coming to the Hospital, Ms. Iadarola was the Vice President of Patient Care Services at Charlotte Hungerford Hospital in Torrington, Connecticut. She had worked in progressive management positions during her 14 years there. Ms. Iadarola holds a Bachelor of Science degree in nursing from the University of Connecticut, a Masters of Business Administration with a healthcare concentration from Rensselaer Polytechnic Institute, and is a Certified Professional in Healthcare Quality.

Diane Woolley, Vice President, Human Resources. Ms. Woolley joined the Hospital in March 2007 as Administrative Director of Human Resources and has held the position of Vice President since July 2011. Prior to coming to the Hospital, Ms. Woolley served as Director of Human Resources with Smiths Interconnect/Times Microwave Systems for seven years and with United Technologies Corporation for

eight years. Ms. Woolley holds an MBA, a Master's of Science in Human Resource Management both from Rensselaer at Hartford, and a Bachelor of Science degree from Post University.

Michael Cemeno, Vice President, Chief Information Officer. Mr. Cemeno joined Waterbury Hospital in March 2011 as Chief Information Officer. Prior to coming to the Hospital, Mr. Cemeno served as Associate Chief Information Officer at Yale New Haven Health System for nine years. Prior to becoming Associate CIO, he held the position of Vice President of IT and CIO at Greater Hudson Valley Health System for five years. Mr. Cemeno holds a Bachelor Degree in Business Administration from Temple University in Philadelphia.

David MacDonald, Interim Vice President, Physician Services. Mr. MacDonald joined Waterbury Hospital in May 2011 and is Vice President of Physician Services for Waterbury Hospital and Alliance Medical Group. Prior to working with the Hospital, Mr. MacDonald worked at a major academic medical center in Boston. Founder of Aegle Advisors, Mr. MacDonald spent nearly two decades developing leadership skills in a multitude of areas including healthcare delivery strategy, finance, and operations in a variety of for-profit and not-for-profit healthcare settings. Mr. MacDonald spent several years as a healthcare consultant and attorney in the Commonwealth of Massachusetts. He was also Vice President of Finance, CFO, and In-House Counsel for a healthcare services organization in Southeastern United States. Mr. MacDonald holds a Bachelor of Science degree in Accounting from West Virginia University, a Juris Doctorate from Roger Williams University in Rhode Island, and an Executive MBA from Emory University in Atlanta.

Jay Hoffman, Interim Chief Financial Officer. Mr. Hoffman joined the Hospital in August 2012 as its Interim CFO. He has been operating a transitional firm, JH Enterprises, since 2003, which provides transition management services to hospitals, health systems, and multi-specialty physician group practices. Prior to developing JH Enterprises, he served as Vice President of Finance for Clarian Health Partners (known as IU Health), in Indianapolis; Vice President of Corporate Finance for Parkview Health and CFO of its flagship hospital Parkview Hospital, Fort Wayne; Chief Financial Officer of St. Joseph Hospital, Lancaster, PA; Vice President of Finance, Summa Health System, Akron, OH; and Hospital Management Professionals, Inc., Naperville. Mr. Hoffman holds an MBA from LaSalle University, Philadelphia and a Bachelor of Science degree from The Pennsylvania State University. He is a Certified Public Accountant and a Fellow in HFMA.

John Evans, FACHE, Interim Chief Operating Officer. Mr. Evans joined Waterbury Hospital in April 2011 as the Interim COO. Prior to Waterbury he was President of Strategic Alliance Advisors (s2a) for six years. Prior to s2a he was Chief Operating Officer at Fletcher Allen Healthcare, the academic medical center for Vermont. Prior to Fletcher Allen he served with St. Vincent's Health Services (SVHS) in Bridgeport, CT, first as EVP/COO at St. Joseph Medical Center in Stamford, and then as SVP, Operations at St. Vincent's Medical Center in Bridgeport, CT, the acute care hub for SVHS. Prior to SVHS Mr. Evans was President/CEO of NovaMed for five years, a for-profit diversified health services and technology company. During the first ten years of his career, Mr. Evans served in various healthcare executive positions in the US Army. Mr. Evans holds an MHA from Baylor University and a BA from the University of Vermont.

VII. Financial Overview

A. GWHN Historical Financial Statements

Table 7.1: GWHN and Subsidiaries Historical Income Statement

($ in millions)

	For the Fiscal Years Ended September 30,				
	2007	**2008**	**2009**	**2010**	**2011**
Revenues:					
Net revenues from services to patients	$239.2	$240.0	$258.1	$259.8	$270.7
Investment related income	6.1	1.3	2.7	1.3	1.5
Other operating revenues	4.7	5.0	3.5	6.8	8.0
Service, sales and rental income	3.3	9.2	9.2	3.6	1.6
Unrestricted gifts and bequests	0.2	0.2	0.5	0.2	0.3
Net assets released from restrictions	4.4	4.7	5.1	5.4	5.9
Total Revenue	**$257.9**	**$260.4**	**$279.1**	**$277.1**	**$288.1**
% Growth	*5.0%*	*0.9%*	*7.2%*	*(0.7%)*	*4.0%*
Expenses:					
Salaries, wages and benefits	148.3	154.4	152.1	158.9	174.3
Supplies, utilities and other	78.5	89.3	90.6	90.9	96.8
Bad debt expense	21.9	17.9	14.4	15.7	11.7
Depreciation	11.0	10.5	9.9	9.8	9.5
Operations improvement	-	-	12.9	2.7	0.3
Interest and Amortization	1.9	1.7	1.6	1.9	1.3
Investment fees and bank charges	0.2	0.2	-	-	-
Total Expenses	$261.7	$274.0	$281.6	$279.9	$293.9
Gain (loss) from operations	**($3.8)**	**($13.6)**	**($2.5)**	**($2.9)**	**($5.8)**
Minority interest	(1.4)	(1.1)	(1.3)	(1.0)	(1.1)
Other nonoperating expenses	0.1	(3.1)	0.5	1.4	(2.9)
Total other income (expense)	($1.3)	($4.2)	($0.8)	$0.4	($4.0)
Excess of revenue over expenses	**($5.1)**	**($17.8)**	**($3.3)**	**($2.5)**	**($9.8)**
EBIDA[(1)]	**$9.2**	**($1.2)**	**$21.9**	**$11.6**	**$5.3**
Margin	*3.6%*	*(0.5%)*	*7.9%*	*4.2%*	*1.8%*
Operating Income[(1)]	**($1.8)**	**($11.7)**	**$12.0**	**$1.7**	**($4.2)**
Margin	*(0.7%)*	*(4.5%)*	*4.3%*	*0.6%*	*(1.5%)*

(1) Excludes one-time fees including operations improvement expenses and investment fees and bank charges

Table 7.2: GWHN and Subsidiaries Historical Balance Sheet

($ in millions)

	As of September 30,				
	2007	**2008**	**2009**	**2010**	**2011**
Current Assets					
Cash and cash equivalents	$8.6	$14.5	$19.3	$22.3	$16.7
Short-term investments	0.9	0.9	0.8	0.9	1.0
Accounts receivable, net	36.0	36.9	33.0	32.6	37.0
Other receivables	1.4	0.8	1.1	1.7	2.5
Inventory	0.5	0.6	0.6	0.8	0.9
Prepaid expenses and other	1.5	1.8	1.4	1.4	1.8
Due from third-party reimbursement agencies	-	0.6	-	-	2.6
Due from affiliates	1.1	2.6	1.5	0.2	0.2
Assets whose use is limited and required for current liabilities	3.1	2.7	0.6	0.6	-
Other current assets	0.2	0.3	0.1	-	-
Total Current Assets	$53.4	$61.6	$58.5	$60.5	$62.6
Funds held by trustee	$9.8	$4.8	$0.0	-	-
Funds held in escrow by agreement with CHEFA and trustee	2.6	2.6	2.6	2.6	4.0
Assets whose use is limited and required for current liabilities	(3.1)	(2.7)	(0.6)	(0.6)	-
Funds held in trust by others	47.2	38.5	37.9	39.6	37.3
Long-term investments	48.3	33.2	30.2	32.3	29.0
Board-designated endowment funds	-	-	2.7	2.8	2.6
Other investments	0.2	0.1	0.2	0.3	0.1
Prepaid pension and other investments	1.8	-	-	-	-
Loans and other receivables	1.8	1.1	0.9	0.4	0.2
Accrued interest and dividends receivable	0.1	0.1	0.1	0.1	0.0
Goodwill	-	-	-	-	1.8
CHEFA obligations issue expense	0.8	0.7	0.7	0.7	0.4
Property, plant and equipment, net	63.6	57.4	50.1	45.8	52.0
Total Assets	**$226.5**	**$197.5**	**$183.3**	**$184.4**	**$190.1**
Current Liabilities					
Accounts payable and accrued expenses	$21.5	$30.9	$25.1	$28.7	$38.8
Due to third-party reimbursement agencies	2.5	-	1.2	0.4	-
Current portion of CHEFA obligations	0.8	0.8	0.9	0.9	0.5
Current portion of notes payable	5.9	5.0	0.4	0.5	0.6
Due to affiliates	-	0.4	-	0.0	0.0
Total Current Liabilities	$30.7	$37.1	$27.6	$30.6	$39.9
Other noncurrent liabilities	$8.9	$7.8	$14.4	$14.7	$19.8
CHEFA obligations	22.2	21.4	20.5	19.7	26.6
Notes payable	1.8	0.6	0.6	0.7	1.5
Minority interest	2.5	2.4	2.5	2.9	3.2
Total Liabilities	$66.1	$69.3	$65.6	$68.6	$91.1
Net Assets					
Unrestricted	$96.8	$76.2	$69.3	$65.2	$52.4
Temporarily restricted	13.5	10.7	7.8	8.3	6.5
Permanently restricted	50.0	41.3	40.7	42.4	40.1
Total Net Assets	$160.3	$128.2	$117.7	$115.9	$99.0
Total Liabilities and Net Assets	**$226.5**	**$197.5**	**$183.3**	**$184.4**	**$190.1**

B. Waterbury Hospital Historical Financial Statements

Table 7.3: Waterbury Hospital and Subsidiaries Historical Income Statement

($ in millions)

	For the Fiscal Years Ended September 30,					LTM
	2007	2008	2009	2010	2011	July 2012
Revenues:						
Net revenues from services to patients	$234.7	$235.3	$253.5	$254.8	$265.9	$271.8
Other operating revenues	4.6	5.2	3.3	6.6	7.9	7.4
Net assets released from restrictions	4.4	4.7	5.1	5.4	5.9	5.9
Total Revenue	**$243.8**	**$245.2**	**$261.9**	**$266.8**	**$279.7**	**$285.0**
% Growth	*5.0%*	*0.6%*	*6.8%*	*1.9%*	*4.8%*	
Expenses:						
Salaries and benefits	140.0	144.0	142.8	153.2	169.7	161.5
Supplies and Other	74.7	80.9	82.0	87.6	95.0	103.2
Bad debts	21.9	17.9	14.4	15.7	11.7	11.7
Depreciation	10.6	10.1	9.6	9.6	9.3	9.7
Operations Improvement	-	-	12.9	2.7	0.3	-
Interest and Amortization	1.7	1.6	1.5	1.8	1.2	1.2
Total Expenses	$248.9	$254.5	$263.2	$270.6	$287.2	$287.3
Gain (loss) from operations	**($5.1)**	**($9.2)**	**($1.3)**	**($3.8)**	**($7.5)**	**($2.2)**
Minority interest	(1.4)	(1.1)	(1.3)	(1.0)	(1.1)	(0.9)
Unrestricted gift and bequests	0.1	0.1	0.4	0.2	0.3	0.3
Investment income	1.9	1.9	1.6	1.6	1.7	1.7
Realized (losses) gains on sales of investments	0.1	(0.0)	(0.0)	0.0	-	-
Other nonoperating expenses	0.1	(0.1)	1.0	(0.8)	(1.8)	(1.8)
Total other income (expense)	$0.8	$0.8	$1.8	($0.0)	($1.0)	($0.7)
Excess of revenue over expenses	**($4.3)**	**($8.5)**	**$0.5**	**($3.8)**	**($8.5)**	**($2.9)**
EBIDA[(1)]	**$7.2**	**$2.5**	**$22.7**	**$10.3**	**$3.3**	**$8.7**
Margin	*2.9%*	*1.0%*	*8.7%*	*3.9%*	*1.2%*	*3.0%*
Operating Income[(1)]	**($3.4)**	**($7.6)**	**$13.1**	**$0.7**	**($6.0)**	**($1.0)**
Margin	*(1.4%)*	*(3.1%)*	*5.0%*	*0.3%*	*(2.1%)*	*(0.3%)*

(1) Excludes one-time fees including operations improvement expenses

Table 7.4: Waterbury Hospital and Subsidiaries Balance Sheet as of July 31, 2012

($ in millions)

ASSETS		**LIABILITIES & NET ASSETS**	
Cash & Cash Equivalents	$17.9	Accounts Payable	$13.6
Net Accounts Receivable	40.9	Accrued Expenses	14.0
Due from Affiliates	(7.1)	Accrued Pension	10.3
Other Investments	4.4	Long-Term Debt	29.3
Net Property, Plant & Equipment	47.6	Due to Third-Party Payors	(2.2)
Other Assets	7.3	Other Liabilities	13.4
		Minority Interest in Net Assets of Affiliates	3.0
		Net Assets	29.5
Total Assets	**$110.9**	**Total Liabilities & Shareholders' Equity**	**$110.9**

Table 7.5: Waterbury Hospital and Subsidiaries Historical Balance Sheet

($ in millions)

	As of September 30,				
	2007	**2008**	**2009**	**2010**	**2011**
Current Assets					
Cash and cash equivalents	$8.0	$13.6	$18.6	$21.4	$15.4
Short-term investments	0.3	0.3	0.4	0.4	0.4
Accounts receivable, net	35.4	35.7	32.4	31.8	36.4
Other receivables	1.4	0.8	1.1	1.7	2.5
Inventory	0.5	0.6	0.6	0.8	0.9
Prepaid expenses and other	1.5	1.8	1.4	1.4	1.7
Due from third-party reimbursement agencies	-	0.8	-	-	2.9
Due from affiliates	4.0	-	0.9	-	3.8
Assets whose use is limited and required for current liabilities	3.1	2.7	0.6	0.6	-
Total Current Assets	$54.1	$56.4	$55.8	$58.1	$64.0
Funds held by trustee	$9.8	$4.8	$0.0	-	-
Funds held in escrow by agreement with CHEFA and trustee	2.5	2.6	2.6	2.6	4.0
Assets whose use is limited and required for current liabilities	(3.1)	(2.7)	(0.6)	(0.6)	-
Other Long Term Assets					
Funds held in trust by others	47.2	38.5	37.9	39.6	37.3
Long-term investments	15.4	12.7	9.6	10.1	8.8
Board-designated endowment funds	-	-	2.7	2.8	2.6
Other receivables	1.5	0.9	0.7	0.1	0.0
Due from affiliates	-	-	4.9	5.7	-
Prepaid pension and other investments	1.8	-	-	-	-
Goodwill	-	-	-	-	1.8
CHEFA obligations issue expense	0.7	0.6	0.6	0.6	0.4
Property, plant and equipment, net	59.4	53.4	45.8	43.3	49.6
Total Assets	**$189.4**	**$167.2**	**$160.0**	**$162.3**	**$168.5**
Current Liabilities					
Accounts payable and accrued expenses	$11.7	$20.3	$15.8	$19.0	$27.3
Accrued salaries	8.6	9.2	8.2	9.2	10.1
Due to third-party reimbursement agencies	2.4	-	1.0	0.2	-
Current portion of CHEFA obligations	0.8	0.8	0.8	0.9	0.4
Current portion of notes payable	5.1	1.2	0.3	0.5	0.6
Due to affiliates	-	0.7	-	0.2	-
Total Current Liabilities	$28.5	$32.2	$26.2	$29.9	$38.4
Other noncurrent liabilities	$8.9	$7.8	$14.4	$14.7	$19.8
CHEFA obligations	20.5	19.8	19.0	18.1	25.2
Notes payable	1.7	0.5	0.3	0.7	1.5
Minority interest	2.5	2.4	2.5	2.9	3.2
Total Liabilities	$62.2	$62.7	$62.3	$66.4	$88.1
Net Assets					
Unrestricted	$63.7	$52.4	$49.3	$45.2	$33.7
Temporarily restricted	13.5	10.7	7.8	8.3	6.5
Permanently restricted	50.0	41.3	40.7	42.4	40.1
Total Net Assets	$127.2	$104.5	$97.7	$95.9	$80.3
Total Liabilities and Net Assets	**$189.4**	**$167.2**	**$160.0**	**$162.3**	**$168.5**

XIII. Appendices

Appendix A – Response Matrix

Transaction Element	Description
1. Form of Transaction	a) Please describe the structure of the proposed transaction and resulting relationship with the surviving GWHN organization.
2. Objectives Alignment	Please describe how you envision achieving GWHN's Objectives: a) Ensure Waterbury Hospital remains a viable health care entity, providing the highest safety and quality health care services to the Greater Waterbury community for the long-term; b) Provide sufficient capital to meet deferred, current and future capital needs for the Waterbury Hospital physical plant to ensure state of the art health care delivery services through an upgrade of facilities, equipment and technology; c) Continue a meaningful, local governance presence at Waterbury Hospital that represents both physicians and the Greater Waterbury community; d) Develop and implement an ambulatory service strategy to best position the Company for successful transition in changing health care delivery methods; e) Develop and implement regional tertiary care relationships for the betterment of health care delivery to the community; f) Deploy repeatable and scalable tools and clinical care services to continually improve the health of the community; g) Enhance the Hospital's medical staff by attracting and retaining physicians through access to available capital partner funds to support such growth; h) Maintain high satisfaction scores by patients, physicians, employees and volunteers; and i) Continue charitable care delivery and funding.
3. Ownership, Governance and Management	a) Describe how GWHN will be organized in relation to your organization. b) Describe the proposed governance structure and the ongoing role, if any, of GWHN's current Board of Directors. c) Describe the proposed management organizational structure for GWHN.
4. Transaction Value	If you are proposing an asset purchase, please describe how GWHN will be valued, including the methodology and calculation of any adjustments to the proposed consideration.
5. Maintenance of Clinical Services	a) Describe your commitment to maintaining existing clinical services. b) Describe any new services you anticipate implementing over the next five years. c) Describe which, if any, clinical services may not be maintained at GWHN and the Hospital. d) Indicate the minimum time horizon for maintaining existing services.
6. Excluded Activities and Operations	a) Describe any GWHN activities and operations that are expected to be excluded from a transaction. b) Describe how the surviving GHWN organization (if any) could support the ongoing activities of the acquired operations after the transaction.

Transaction Element	Description
7. Charity Care	Describe your existing charity and indigent care policies and any potential changes to GWHN policies you foresee.
8. Ethical and Religious Directives	Describe any ethical or religious directives of your organization, if any, which would impact the future operations of GWHN.
9. Employee Relationships	a) Describe your commitment to GWHN employees, anticipated layoffs, and type of severance package that may be offered to any affected employees. b) Describe any anticipated employee benefit changes.
10. Capital Expenditure Commitments	Describe your expectations and commitment to capital investments over the next five years to improve GWHN facilities and expand programs and services.
11. No Sale	Describe your commitment to retaining ownership of the GWHN operations acquired.
12. Right of First Refusal/Repurchase Rights	Describe any terms and conditions under which the surviving GWHN organization (if any) could reacquire interests transferred in a transaction.
13. Financial and Operating Information	a) Provide a copy of your most recent audited financial statements. b) Describe how you propose to finance the transaction and any proposed ongoing financial commitments to GWHN. c) Provide an overview of your existing operations, including, but not limited to, the following: (i) Number and location of facilities owned and operated (ii) Number of beds owned and operated (iii) Key operating statistics (iv) Key quality indicators
14. Due Diligence	a) Describe your due diligence process. b) Provide a list of due diligence items you would like to receive in Phase II if you are selected to continue in the process.
15. Process and Approvals	Indicate the level at which your response has been approved within your organization and what approvals will be required to sign a Definitive Agreement and to close the transaction.
16. Other	Please describe any other factors that GWHN should consider in evaluating your proposal.

Appendix B – 2011 GWHN Audited Financials

See Separate PDF© File

Appendix C – 2011 Hospital Audited Financials

See Separate PDF© File

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EXHIBIT Q6-1

CONFLICT OF INTEREST/FINANCIAL DISCLOSURES - GWHN

Conflict of Interest/Financial Disclosure Form

The Application of the Greater Waterbury Health Network, Inc. and its Affiliates ("GWHN") and Prospect Medical Holdings, Inc. ("Prospect") to the Connecticut Attorney General and the Connecticut Department of Public Health requests permission to sell substantially all of the assets of GWHN to Prospect and operate the facility known as The Waterbury Hospital as a subsidiary or affiliate of Prospect (the "New Hospital").

---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Darlene Stromstad

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO ____ YES. If YES, please provide details.

(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

9/15/15
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
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APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: MICHAEL CARMENO

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

X NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

X NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

X NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

X NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

X NO _____ YES. If YES, please provide details.

_____

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_____

(ii) Leased assets to or leased assets from a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

_____ _____

Signature Date 9/10/2015

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
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PHP Holdings, Inc.	Delaware/LLC
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(a) Please provide the following information:

Print Name: David J. Pizzuto, MD

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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_____ NO ✓ YES. If you answered YES, please note the name of the entity and income generated from the entity.

Chairman Board of Managers - Prospect Provider Group CT-Waterbury LLC. No income to date

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

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_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

9-16-15
Date

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StarCare Medical Group, Inc.	California/Corporation
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1. **Instructions:**

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(a) Please provide the following information:

Print Name: MARK HOLTZ

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

_X_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

_X_ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

_X_ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

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_____

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(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

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X NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Mark Hoz
Signature

September 16, 2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
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Prospect ACO RI, LLC	Delaware/LLC
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Prospect Health Plan, Inc.	Delaware/Corporation
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Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
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Conflict of Interest/Financial Disclosure Form

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: JAMES J. MOYNAN

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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✓ NO ____ YES. If YES, please provide details.

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(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

James J. Moyle
Signature

9/17/2015
Date

Exhibit A

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Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
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ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
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PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
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Nix SPE, LLC	Texas/LLC
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New Genesis Medical Associates, Inc.	California/Corporation
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Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
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APAC Medical Group, Inc.	California/Corporation
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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: John Camus

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

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✓ NO _____ YES. If YES, please provide details.

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✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 9-16-15

Signature Date

Exhibit A

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Alta Newport Hospital, Inc.	California/Corporation
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Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
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Prospect NJ, Inc.	Delaware/Corporation
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1. **Instructions:**

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(a) Please provide the following information:

Print Name: Sandra A. Iadarola

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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X NO ____ YES. If YES, please provide details.

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Sandra C Sadarka
Signature

9/16/15
Date

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(a) Please provide the following information:

Print Name: Richard P Knopp

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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____ NO ____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

____ NO ____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

____ NO ____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

____ NO ____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

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_____

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(ii) Leased assets to or leased assets from a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Richard P Knopp
Signature

9/16/2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
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Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
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Prospect ACO CA, LLC	Delaware/LLC
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Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Patricia Gentil

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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X NO _____ YES. If YES, please provide details.

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(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Patricia Smith
Signature

9-16-15
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
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Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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Prospect Health Services NJ, Inc.	Delaware/Corporation

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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
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Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
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Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

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---

1. Instructions:

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Carl Contadini

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. Definitions:

(a) Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

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X NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

X NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

X NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

_____ 10-2-2015

Signature Date

Exhibit A

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Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
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Prospect NJ, Inc.	Delaware/Corporation
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Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
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(a) Please provide the following information:

Print Name: William J. Pizzuto

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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Signature

09/15/15
Date

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(a) Please provide the following information:

Print Name: Carl Shuster, MD

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(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

__X__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

__X__ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

__X__ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

__X__ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

__X__ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_X_ NO ____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Paul Shapiro MD
Signature

9/14/15
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
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Prospect Health Services NJ, Inc.	Delaware/Corporation

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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
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Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
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APAC Medical Group, Inc.	California/Corporation
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Conflict of Interest/Financial Disclosure Form

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Patricia A. McKinley

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

_✓_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

_✓_ NO _____ YES. If YES, please provide details.

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(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

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_____

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✓ NO _____ YES. If YES, please provide details.

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(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Patricia A. McKinley
Signature

September 15, 2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
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Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
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New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
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Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
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Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
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APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: FRANK SHERER

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

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(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

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(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

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✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 9/15/2015

Signature Date

Exhibit A

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Alta Newport Hospital, Inc.	California/Corporation
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Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
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Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
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Nix SPE, LLC	Texas/LLC
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(a) Please provide the following information:

Print Name: Henry Borkowski M.D

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature _____ Date 9/30/15

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(a) Please provide the following information:

Print Name: Ronald D'Andrea, M.D.

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

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(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

__✓__ NO _____ YES. If YES, please provide details.

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(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

__✓__ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

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____ NO ____ YES. If YES, please provide details.

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____ NO ____ YES. If YES, please provide details.

(iii) Been indebted to or loaned money to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

____ NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature 9.30.15 Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
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Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
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ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
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New Genesis Medical Associates, Inc.	California/Corporation
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1. **Instructions:**

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(a) Please provide the following information:

Print Name: Neil F. Petersen

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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2. **Definitions:**

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3. **Financial Interests**

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Signature

27 Sept 15
Date

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---

1. **Instructions:**

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(a) Please provide the following information:

Print Name: JOHN A. KELLY, JR

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

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I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

20 September 2015
Date

Exhibit A

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(a) Please provide the following information:

Print Name: James H. Gatling

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James H. Gatlin
Signature

9-14-15
Date

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(a) Please provide the following information:

Print Name: John Michaels

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✓ NO _____ YES. If YES, please provide details.

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(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 10-2-15

Signature Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type o Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
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Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
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Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
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---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: SUNDAE Black

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

__✓__ NO ____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

__✓__ NO ____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

__✓__ NO ____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

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_____

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✓ NO _____ YES. If YES, please provide details.

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✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

10/12/15
Date

Exhibit A

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Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
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Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
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Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: James Cain

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

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(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

_____ NO X YES. If you answered YES, please note the name of the entity and income generated from the entity.

We provided a fairness opinion to Prospect Medical that was unrelated to GWHN. Total fees & expenses were $125,000

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

_____ NO X YES. If YES, please provide details.

Cain Brothers is advisor to GWHN

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

X NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

X NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

X NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

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__X__ NO _____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

__X__ NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

__X__ NO _____ YES. If YES, please provide details.

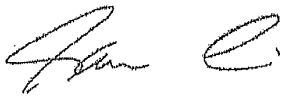
_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

_____ NO, __X__ YES. If YES, please provide details.

See Section 3(b) above.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

October 19, 2015

Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
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Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
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Prospect Health Services NJ, Inc.	Delaware/Corporation

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Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
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Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
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(a) Please provide the following information:

Print Name: Chris McDonough

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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_____ NO X YES. If YES, please provide details.

Cain Brothers is advisor to GWHN

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X NO _____ YES. If YES, please provide details.

_____

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_____

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____ NO X YES. If YES, please provide details.

See Section 3(b) above

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

10/19/15
Date

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1. **Instructions:**

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(a) Please provide the following information:

Print Name: Patrick J. Simers

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

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3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

_X_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

_X_ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

_X_ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

_X_ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

_X_ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

_X_ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_X_ NO ____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

_X_ NO ____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Patrick J Semon
Signature

9-28-2015
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
Prospect Hospital Holdings, LLC	Texas/LLC
Nix Hospitals System, LLC	Texas/LLC
Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

Conflict of Interest/Financial Disclosure Form

The Application of the Greater Waterbury Health Network, Inc. and its Affiliates ("GWHN") and Prospect Medical Holdings, Inc. ("Prospect") to the Connecticut Attorney General and the Connecticut Department of Public Health requests permission to sell substantially all of the assets of GWHN to Prospect and operate the facility known as The Waterbury Hospital as a subsidiary or affiliate of Prospect (the "New Hospital").

---

1. **Instructions:**

This Disclosure Form is for GWHN (i) board members and officers, (ii) experts and (iii) key employees (senior executives with managerial responsibilities who have direct involvement in the proposed transaction).

(a) Please provide the following information:

Print Name: Ann H. Zucker

(b) **PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE NO LATER THAN Tuesday, September 1, 2015 to azucker@carmodylaw.com or Carmody Torrance Sandak & Hennessey LLP, Ann Zucker, 707 Summer Street, Stamford, CT 06901.** If you have any questions regarding the questionnaire, please call her at 203-252-2652.

(c) Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this questionnaire, please notify Ann Zucker of any such event or information as soon as possible.

2. **Definitions:**

(a) Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or an entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) Prospect Entity: The Prospect Entity includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates shown on Exhibit A.

3. **Financial Interests**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant, contractor, with any Prospect Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed transaction?

✓ NO _____ YES. If YES, please provide details.

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Entity?

✓ NO _____ YES. If YES, please provide details.

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Prospect Entity or the New Hospital?

✓ NO _____ YES. If YES, please provide details.

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Prospect Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details.

_____

(ii) Leased assets to or leased assets from a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iii) Been indebted to or loaned money to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Entity.

✓ NO _____ YES. If YES, please provide details.

_____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Anne N. Fonbuena
Signature

9.22.15
Date

Exhibit A

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware/Corporation
Ivy Intermediate Holding Inc.	Delaware/Corporation
Prospect Medical Holdings, Inc.	Delaware/Corporation
Alta Hospitals System, LLC	California/LLC
Alta Los Angeles Hospitals, Inc.	California/Corporation
Alta Newport Hospital, Inc.	California/Corporation
Southern California Healthcare System, Inc.	California/Corporation
Prospect Medical Systems, Inc.	Delaware/Corporation
ProMed Health Care Administrators	California/Corporation
Prospect Medical Group, Inc.	Delaware/Corporation
Prospect Health Source Medical Group, Inc.	California/Corporation
Prospect Professional Care Medical Group, Inc.	California/Corporation
Prospect NWOC Medical Group, Inc.	California/Corporation
StarCare Medical Group, Inc.	California/Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California/Corporation
Pomona Valley Medical Group, Inc.	California/Corporation
Upland Medical Group, a Professional Medical Corporation	California/Corporation
Nuestra Familia Medical Group, Inc.	California/Corporation
AMVI/Prospect Medical Group	California/Joint Venture
Prospect Provider Groups, Inc.	Delaware/Corporation
Prospect Provider Group RI, LLC	Delaware/LLC
Prospect Provider Group NJ, LLC	Delaware/LLC
Prospect NJ, Inc.	Delaware/Corporation
Prospect EOGH, Inc.	New Jersey/Corporation
Prospect ACO Holdings, LLC	Delaware/LLC
Prospect ACO CA, LLC	Delaware/LLC
Prospect ACO TX, LLC	Delaware/LLC
Prospect ACO RI, LLC	Delaware/LLC
PHP Holdings, Inc.	Delaware/LLC
Prospect Health Plan, Inc.	Delaware/Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware/Corporation
Prospect Health Services NJ, Inc.	Delaware/Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
Prospect Hospital Holdings, LLC	Texas/LLC
Nix Hospitals System, LLC	Texas/LLC
Nix Services, LLC	Texas/LLC
Nix SPE, LLC	Texas/LLC
Nix Community General Hospital, LLC	Texas/LLC
Chaparral Medical Group, Inc.	California/Corporation
New Genesis Medical Associates, Inc.	California/Corporation
New University Medical Group, LLC	Rhode Island /LLC
Prospect CharterCARE, LLC	Rhode Island /LLC
Prospect CharterCARE RWMC, LLC	Rhode Island /LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island /LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island /LLC
Prospect CharterCARE Physicians, LLC	Rhode Island /LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island /LLC
Prospect East Hospital Advisory Services, LLC	Delaware/LLC
Prospect East Holdings, Inc.	Delaware/Corporation
Prospect Provider Group CT – Waterbury, LLC	Delaware/LLC
Prospect Provider Group CT – ECHN, LLC	Delaware/LLC
Prospect Health Services CT, Inc.	Delaware/Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware/Corporation
Coordinated Regional Care Group, Inc.	Delaware/Corporation
Prospect Hospital Advisory Services, Inc.	Delaware/Corporation
Alta Metro Hospital, Inc.	California/Corporation
Prospect Raritan, Inc.	New Jersey/Corporation
APAC Medical Group, Inc.	California/Corporation
Santa Ana/Tustin Physicians Group, Inc.	California/Corporation

EXHIBIT 6-2

CONFLICT OF INTEREST/FINANCIAL DISCLOSURE FORMS (PMH)

PMH CONFLICT OF INTEREST DISCLOSURES
GWHN TRANSACTION

Name	**Affiliation**
Alyse Wagner	Director, BOD
John Baumer	Director, BOD
Michael Solomon	Director, BOD
Sam Lee	Chairman, BOD; CEO, PMH
Dr. Jeereddi Prasad	Director, BOD, President, ProMed
Dr. Mitchell Lew	President, PMH
Steve Aleman	CFO, PMH
Ellen Shin	General Counsel & Secretary, PMH
David Topper	President, Alta
Jonathan Spees	SVP, M&A, PMH
Von Crockett	SVP, Corporate Development, PMH
Steve O'Dell	SVP, CRC, PMH
Thomas Reardon	President, Prospect East
Gary Herschman	Epstein, Becker
Michele Volpe	Bernstein, Volpe
Jay Krupin	Baker Hostetler
Elizabeth Dold	Groom Law Group
Alan Weiss	Lockton
Jim Tinyo	Keenan
Arthur Rains-McNally	Milliman
Chris Kujawa	Ernst & Young LLP
Rosemary Free	Ernst & Young LLP

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Alyse Wagner

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Alyse Wagner
Signature

9/18/15
Date

Alyse Wagner
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: JOHN BAUMER

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

JBaumer
Signature

10-8-2015
Date

JOHN BAUMER
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michael Solomon

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/18/15
Date

Michael Solomon
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: SAM LEE

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

_✓_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

_✓_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9-21-15
Date

SAM LEE
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: K PRASAD JEGADDI

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

_____ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

_____ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_____ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO _____ YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

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_____ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature Date

PRASAD JEEREDDI

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form,,) is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN,,) and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Mitchell Lew

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

_✓_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

_✓_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Mitchell Lew 9/27/15

Signature Date

Mitchell Lew

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: STEVE ALEMAN

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/18/15
Date

STEVE ALEMAN
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Ellen Shin

(b) Please complete and return the Disclosure Form no later than September 25, 2015 to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

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✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 10/7/15

Eileen Shin
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: DAVID TOPPER

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

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(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

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_____

[*Continues on the Following Page*]

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✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ _____

Signature Date

DAVID TOPPER

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: JONATHAN SPEES

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. NOTE: TRANSACTIONS ARE MY PRINCIPAL JOB RESPONSIBILITY & THE PROPOSED TRANSACTION WILL BE CONSIDERED IN MY OVERALL PERFORMANCE EVALUATION & BONUS CALCULATION.

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/9/15
Date

JONATHAN SLOSS
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Toni Crockett

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

_✓_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

_✓_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

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_____

[*Continues on the Following Page*]

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✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9-17-15

Printed Name Dana L. Crockett

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: STEPHEN T. O'DELL

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

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_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

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(iii) Been indebted to or loaned money to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/9/15
Date

STEPHEN T. O'DELL
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Thomas M. Rogers

(b) **Please complete and return the Disclosure Form no later than September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. ***Financial Interests:***

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

☆ _____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

☆ TRANSACTIONS ARE A SUBSTANTIAL PART OF MY JOB RESPONSIBILITIES AND THE PROPOSED TRANSACTION WILL BE CONSIDERED IN MY OVERALL PERFORMANCE AND BONUS CALCULATION.

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/8/15
Date

THOMAS M. REARDON
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

   (a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

   Please provide the following information:

   Print Name: Gary Herschman

   (b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

   (c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

   (a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Gary Herschman 9/24/2015

Signature Date

Gary Herschman

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michele Volpe

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

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(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

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_____

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_____

[*Continues on the Following Page*]

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✓ NO _____ YES. If YES, please provide details. _____

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✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9/18/15

Michele Volpe
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Jay P. Krupin on behalf of Baker & Hostetler LLP

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

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_____

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_____

[*Continues on the Following Page*]

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__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ Sept. 21, 2015

Signature Date

Jay P. Krupin

Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Elizabeth T. Dold

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **GWHN Entity** is Greater Waterbury Health Network ("GWHN"), VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/17/2015
Date

Elizabeth T. Dold
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: ALAN WEISS

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since _____, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any GWHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

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✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

[signature] 9/17/2015

Signature Date

ALAN M WEISS

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: James D. Tinyo

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a GWHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a GWHN Entity?

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__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9-17-15
Date

James D. Tinyo
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form (the "Disclosure Form") is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Greater Waterbury Health Network ("GWHN") and its affiliates, including VNA Health at Home, Inc., Greater Waterbury Management Resources, Inc. and The Waterbury Hospital, including its wholly-owned subsidiaries Alliance Medical Group, Inc. and Cardiology Associates of Greater Waterbury, LLC, to a for-profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Arthur Rains-McNally

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person** is a person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a GWHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

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_✓_ NO _____YES. If YES, please provide details. _____

_____

[*Continues on the Following Page*]

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_____ NO _____ YES. If YES, please provide details. _____

_____

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_____

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_____ NO _____ YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ 10/5/15

Signature Date

Arthur Rains-McNally

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: CHRIS KUJAWA

(b) Please complete and return the Disclosure Form no later than September 25, 2015 to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

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(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any GWHN Entity (see definitions above)?

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

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__X__ NO _____YES. If YES, please provide details. _____

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[*Continues on the Following Page*]

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__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/12/2015
Date

CHRIS KUJAWA
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: ____Rosemary Free Ernst & Young LLP_____

(b) Please complete and return the Disclosure Form no later than **September 25, 2015** to Christine Cohn, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Christine Cohn at (310) 696 4737.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Christine Cohn, christine.cohn@prospectmedical.com of any such event or information as soon as possible.

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any GWHN Entity?

___X___ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

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_____

[*Continues on the Following Page*]

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__X____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a GWHN Entity?

___X___ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or acquired goods, services or facilities to a GWHN Entity?

__X____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

____ Digitally signed by rosemary.perkins@ey.com DN: cn=rosemary.perkins@ey.com Date: 2015.10.08 15:34:16 -04'00' _____ _____10.8.15_____
Signature Date

__Rosemary P Free_____
Printed Name

EXHIBIT 6-3

CODE OF BUSINESS CONDUCT (PMH)

Code of Business Conduct
Ethical Business Practice

As approved by the Board of Directors on September 10, 2013

A Message to Directors and Employees:

As Directors and employees of Prospect Medical Holdings, Inc and its subsidiaries (referred to in the following pages as "Company"), we are responsible for conducting the business affairs of the Company in accordance with applicable laws, in an honest manner, and with the highest professional and ethical standards.

To make certain that we understand what is expected of us, the Company and its Board of Directors have adopted the following policies.

This Code of Business Conduct / Ethical Business Practice and the incorporated corporate policies (collectively, "Code") contain commonsense rules of conduct. We ask that you read the Code carefully and completely, because it is essential that you fully comply with these policies in the future. If you have any questions, talk them over with your manager or another member of management. Alternatively, feel free to contact the Human Resources or Legal Departments.

Please sign the acknowledgment page confirming that you have received the Code, understand it represents mandatory policies of the Company and agree to abide by it. Return the signed copy to the Human Resources Department where it will be placed in your personnel file and keep the Code for future reference.

Thank you for your attention to this important matter.

Sincerely,

Samuel S. Lee
Chairman and Chief Executive Officer

Code of Business Conduct / Ethical Business Practice

Directors and employees of the Company, its subsidiaries and affiliated companies, are to conduct their business affairs in accordance with the highest ethical standards. Policies are to be applied in good faith with reasonable business judgment to enable the Company to achieve its operating and financial goals within the framework of the law. Directors and employees shall not conduct themselves in a manner that is directly or indirectly detrimental to the best interests of the Company or in a manner which would bring financial or any other gain to any Director or employee at the expense of the Company. Ethical as well as legal obligations will be fulfilled openly, promptly, and in a manner that will reflect positively on the Company's name.

Agreements, whether written or verbal, will be honored. No bribes, bonuses, kickbacks, lavish entertainment, or gifts will be exchanged for special position, price, or privilege. It is Company policy that contracts are reviewed by legal counsel. By contract, we mean each agreement, memorandum of understanding, or other document or arrangement that could reasonably be expected to impose an obligation. Please bear in mind that your conduct and/or your conversations may have, under certain circumstances, the unintended effect of creating an obligation which the Company cannot meet.

The Company requires Directors and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. Directors and employees must practice honesty and integrity in every aspect of dealing with other Directors and employees, the public, the business community, stockholders, customers, members and government authorities.

Directors and employees will maintain the confidentiality of the Company's sensitive or proprietary information and will not use such information for their personal benefit or the benefit of another person or entity. Directors and employees shall refrain, both during and after their employment, from publishing any oral or written statements about the Company or any of its Directors or employees that are slanderous, libelous or defamatory. Statements disclosing private or confidential information about their business affairs or constituting an intrusion into their private lives should be avoided.

Directors and employees will comply with the stock ownership requirements set forth by the Board of Directors, which may relate to the ownership of stock in the Company's parent company or other affiliates.

The Company prohibits unlawful discrimination against Directors and employees, stockholders, members, customers or suppliers on account of race, color, religion, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition, or any other consideration made unlawful by applicable laws. All persons shall be treated with dignity and respect and they shall not be interfered with in the conduct of their duties and responsibilities.

Directors and employees should not be misguided by any sense of loyalty to the Company or a desire for profitability that might cause them to disobey any applicable law or Company policy. Illegal behavior on the part of any Director or employee in the performance of Company duties will not be condoned or tolerated.

The Company is committed to evaluating the effectiveness of the Code through various efforts on an ongoing basis. Adherence to and support of the Code is a condition of employment. Violation may result in disciplinary action, which may include termination.

The Code will be distributed to new Directors and employees and be distributed again to all Directors and employees on an annual basis. Directors and employees are required to sign the acknowledgment confirming they have received the Code, read it and understand it represents mandatory policies of the Company and agree to abide by it. The Company welcomes any suggestions to help improve its business conduct.

Directors and employees can report violations of the law or the Code by calling the Ethics and Compliance Hotline at (877) 814-9252. The Hotline is open 24 hours a day, 7 days a week, and is operated by an independent company. Directors and employees may remain anonymous and translators are available.

Antitrust & Competition

No Director or employee of the Company shall enter into any understanding, agreement, plan or scheme, express or implied, formal or informal, with any competitor to fix prices, contract terms, territories or customers. Authorized senior management of the Company must authorize any discussion with competitors in connection with a project in which the competitor is an alliance partner, joint venturer or subcontractor.

Directors and employees responsible for the conduct or practices of the Company which could in any way involve antitrust or anti-competitive activities should consult with their manager or another appropriate member of management about such matters.

There shall be no exception to this Policy, nor shall it be compromised or qualified by anyone acting for or on behalf of the Company.

Bribery

The Company prohibits payment to suppliers or customers in the form of bribes, kickbacks or payoffs. Directors and employees are also prohibited from receiving, directly or indirectly from a third party, anything of a significant value (other than salary or other ordinary compensation paid by the Company) in connection with a transaction entered into by the Company.

The Company also prohibits Directors and employees from paying any bribe, kickback or other similar unlawful payment to, or otherwise entering into a sensitive transaction with, any public official, political party, candidate for public office or other individual, to secure any contract,

concession or other favorable treatment for the Company or for personal gain. Any extraordinary payments, including extravagant entertainment or gifts of significant value (in general this means the cost will exceed $100), for the express purpose of obtaining or retaining business or unduly influencing some matter in favor of the Company is prohibited. Directors and employees who make such agreements are subject to appropriate action by the Company, as well as the legal consequences of applicable law.

Bribes, kickbacks and payoffs include, but are not limited to: gifts other than nominal value (in general this means the cost will not exceed $100); the uncompensated use of Company services, facilities or property; loans, or loan guarantees or other extensions of credit.

This Policy does not prohibit reasonable expenditures for meals and entertainment of suppliers and customers, which are an ordinary and customary business expense. These expenditures should be included on expense reports and approved under standard Company procedures.

Confidential Information

In carrying out the Company's business, Directors and employees often learn confidential or proprietary information about the Company, its customers, suppliers or members. An unauthorized disclosure could be harmful to the Company or helpful to a competitor.

Therefore, no Director or employee entrusted with or otherwise knowledgeable about information of a confidential or proprietary nature shall disclose or use that information outside the Company or for personal gain, either during or after employment without the valid and proper written authorization from the Company.

The Company also works with proprietary data of suppliers, members and customers. The protection of such data is of the highest importance and must be discharged with the greatest care for the Company to merit the continued confidence of such persons. No Director or employee shall disclose or use confidential or proprietary information owned by someone other than the Company to non-employees without Company authorization, or disclose the information to others unless a need-to-know basis is established.

In general when describing or talking about the Company, it is safe to mention what we do and <u>not</u> how we do it or how much it costs.

Conflicts of Interest

Directors and employees have a duty to the Company to advance the Company's legitimate interests when the opportunity to do so arises. Timely and proper disclosure of possible conflicts of interest that Directors and employees may have in connection with job duties and responsibilities is necessary to protect the best interests of the Company. Possible conflict of interest situations should be promptly and fully disclosed to the Company's senior management.

A conflict of interest may occur if outside activities, personal financial interests, or other interests influence one's ability to make objective decisions in the course of their responsibilities as a Director or employee. A conflict of interest may also exist if the demands of any outside activities hinder or distract Directors or employees from the performance of their responsibilities or cause the individual to use Company resources for other than Company business.

The Company has always been concerned with outside business interests of its Directors and employees that might possibly conflict with the interests of the Company. The Company expects and requires Directors and employees to be honest and ethical in the handling of actual or apparent conflicts of interest between personal and business relationships.

A precise definition of what constitutes a conflict of interest is difficult. There are certain situations which the Company will always consider to be a conflict of interest. These occur if any person having a close personal relationship with the Director or employee, such as, spouse, parents, children, siblings, in-laws, any person living in the same home with the Director or employee or any business associate of the Director or employee:

1. Obtains a significant financial or other beneficial interest in one of the Company's suppliers, customers or competitors without first notifying the Company and obtaining written approval from authorized senior management of the Company;
2. Engages in a significant personal business transaction involving the Company for profit or gain, without first notifying the Company and obtaining written approval from authorized senior management of the Company;
3. Accepts money, gifts, hospitality, loans, guarantees of obligations or other special treatment from any supplier, customer or competitor of the Company;
4. Participates in any sale, loan or gift of Company property without first notifying the Company and obtaining written approval from authorized senior management of the Company;
5. Learns of a business opportunity through association with the Company and discloses it to a third party or invests in or takes the opportunity personally without first notifying the Company;
6. Uses corporate property, information, or position for personal gain; or
7. Competes with the Company.

Equal Opportunity Employer

The Company is an equal opportunity employer and makes employment decisions on the basis of merit. The Company wants to have the best available people in every job. Therefore, the Company does not discriminate, and does not permit its employees to discriminate against other employees or applicants because of race, color, religion, gender, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition, or any other basis protected by applicable federal, state, or local law. Equal employment opportunity

will be extended to all persons in all aspects of the employer-employee relationship, including recruitment, hiring, upgrading, training, promotion, transfer, compensation, benefits, discipline, layoff, recall and termination.

An employee who believes he or she has been or is being subjected to discrimination should bring this matter to the attention of his or her immediate supervisor, department head or Human Resources. If management receives a complaint of discrimination, they shall report the complaint immediately to Human Resources. Nothing in this policy requires any employee complaining of discrimination to present the matter to the person who is the subject of the complaint. All complaints of discrimination will be promptly investigated. The privacy of the persons involved will be protected, except to the extent necessary to conduct a proper investigation. If the investigation substantiates the complaint, immediate action will be taken to end the discrimination, prevent its recurrence and remedy the situation.

An employee who reports discrimination or participates in an investigation related to a complaint of discrimination shall not be retaliated against or adversely treated on the basis thereof.

Fraud & Similar Irregularities

Directors and employees are obligated to protect Company assets and ensure their efficient use. Theft, carelessness and waste of Company assets by Directors and employees may result in their termination and other corrective actions by the Company. Company assets shall be used only for the legitimate business purposes of the Company.

Fraud includes, but is not limited to, dishonest or fraudulent acts; embezzlement; misappropriation of assets; forgery or alteration of negotiable instruments such as Company checks and drafts; taking or using Company supplies or any other Company asset for a purpose other than Company business; unauthorized handling or reporting of Company transactions; and falsification of Company records or financial statements for personal reasons or any other reason.

Directors and employees are obligated to report any fraud, whether material or not to the Company. Reports will be investigated promptly and discreetly. Directors and employees will not suffer adverse consequences as a result of making such a report. However, failure to report a fraud will have a direct negative effect on that person’s relations with the Company.

Policy Against Harassment

The Company is committed to providing a work environment that is free of unlawful discrimination and/or harassment. In keeping with this commitment, the Company maintains a strict policy prohibiting unlawful harassment in the workplace, including sexual harassment, by any employee and by any third parties such as patients, doctors, vendors or visitors. In addition, any harassment of an employee on the basis of race, color, religion, gender, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition or any other protected classification is also strictly prohibited.

The Company considers harassment a serious act of misconduct for which an employee will be disciplined, up to and including immediate discharge. Management who fail to report violations of the Company's Policy Against Harassment will be disciplined , up to and including suspension and termination of employment. The term "harassment" includes sexual, racial, ethnic, and other forms of harassment, including harassment based upon disability.

Some examples of what may be considered harassment, depending on facts and circumstances, include the following:

Sexual Harassment. Unwelcome sexual advances, requests for sexual favors, widespread sexual favoritism, and other verbal, physical or visual conduct of a sexual nature constitute unlawful sexual harassment if (i) submission to such conduct is made an explicit or implicit term or condition of employment; (ii) submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual; or (iii) such conduct has the purpose or effect of either (a) unreasonably interfering with an individual's work performance or (b) creating an intimidating, hostile, or offensive working environment. Sexual harassment includes gender harassment and harassment on the basis of pregnancy, childbirth or related medical conditions, and also includes sexual harassment of an employee of the same gender as the harasser.

Examples of conduct which may violate this Policy include, but are not limited to: offensive or unwelcome sexual flirtations, advances or propositions; threats and demands to submit to sexual requests; offering employment benefits in exchange for sexual favors; making or threatening reprisals after a negative response to sexual advances; widespread sexual favoritism; verbal abuse of a sexual nature; graphic verbal commentaries about an individual's body; sexually degrading words used to describe an individual; sexually-oriented jokes, e-mails, or written materials; visual conduct, including leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters; accessing sexually explicit, pornographic and/or socially offensive websites, chat rooms or other material on the internet or other computer systems; and the unwelcome physical touching of others.

Other Harassment. The Company also will not tolerate any harassment of an employee on the basis of race, gender, religion, color, national origin, sex, sexual orientation, sexual identity, transgender identity, age, ancestry, marital status, disability, medical condition, pregnancy, veteran's status, genetic predisposition or any other protected classification. Examples of such conduct which may violate this policy include, but are not limited to, verbal abuse of a racially derogatory nature; the use of racial or ethnic slurs; racially or ethnically disparaging words used to describe an individual; and racial, ethnic or other derogatory jokes, e-mail, written materials, drawings or cartoons which are racially or otherwise offensive.

Manager Training

As part of the Company's commitment to provide a harassment free workplace, the Company provides and requires training for all managers and supervisors on sexual harassment and other forms of prohibited harassment.

Complaint Procedure

If you believe that you have been discriminated against or you have been harassed by a co-worker, supervisor, patient, or vendor; have witnessed possible discrimination and/or harassment; or if you believe that the Company or another employee has violated any applicable law in the conduct of the Company's business, you have a duty to immediately bring the incident(s) to the attention of Human Resources, or to your supervisor or manager. Any supervisory or managerial employee who receives such a complaint must promptly report it to Human Resources. The description of the incident(s) can be given verbally or in writing.

The matter will be thoroughly investigated, with confidentiality maintained to the extent possible. The Company will promptly investigate the complaint and take appropriate remedial action. It is the obligation of all employees to cooperate fully in the investigation process.

The Company will take action to deter any future discrimination and/or harassment. The Company considers any discrimination and/or harassment to be a serious offense which can result in disciplinary action for the offender, up to and including termination. In addition, disciplinary action will be taken against any employee who attempts to discourage or prevent another employee from bringing discrimination, harassment and/or a violation of law to the attention of management.

Policy Against Retaliation

The Company strictly prohibits retaliation, coercion or intimidation against any person who has, in good faith, opposed harassment or discrimination, filed a complaint of harassment or discrimination, or participated in any proceeding involving a complaint of harassment or discrimination. Any employee who is found to have committed such retaliation will be subject to discipline, up to and including termination. Any employee who experiences or witnesses any conduct believed to be retaliatory should immediately follow the reporting procedures stated above.

Health & Safety

Health and safety is a primary goal of the Company. The Company will comply with all applicable laws to protect the health and safety of its employees in the workplace. Management shall take such actions as are reasonable and necessary to protect Directors, employees and the Company.

To maintain a safe workplace, employees must be safety conscious at all times. Employees must advise their Supervisor or Human Resources if they are aware of any condition presenting a danger so that corrective action may be taken to remove the danger.

Employees should report personal injury, however minor, to the Human Resources Department immediately. First aid kits are readily available in all work areas. In case of emergency, the first person in contact with the injured or ill worker will be responsible for seeking help. The Human Resources Department will assist in obtaining treatment for the injured worker.

Political Activities & Contributions

The Company encourages participation in the political process by its Directors and employees. The federal government and some states have, however, enacted laws regulating campaign contributions in order to limit the political influence of certain types of contributors, such as corporations, to political candidates and participation in political campaigns.

The Company will comply with applicable laws regulating political influence and campaign contributions. The Company believes strongly in the democratic political process and that its Directors and employees should take an active interest in fostering principles of good government in the communities in which they live. Directors and employees may spend their own time and funds supporting political candidates and issues but the Company will not reimburse them for time or funds used for political contributions.

No Director or employee shall apply pressure, direct or implied, that infringes upon an individual's right to decide whether, to whom and in what amount a personal political contribution is to be made. Directors and employees who represent the Company in political and governmental matters must comply with all laws that regulate corporate participation in public affairs.

When permitted by law and authorized by authorized senior management of the Company, Company funds and facilities may be used to inform or influence the voting public on an issue of importance to the business of the Company and its stockholders.

If a Director or employee is asked to make a political contribution and he or she has questions regarding this policy or applicable law, they should consult with authorized senior management of the Company.

Code of Business Conduct and Ethical Business Practice

Acknowledgment of Receipt

I certify that I have received the Prospect Medical Holdings, Inc. Code of Business Conduct and Ethical Business Practice, understand it represents mandatory policies of the Company and agree to abide by it.

Name (please print): _____

Signature: _____

Date: _____

EXHIBIT Q7-1

GWHN REQUEST FOR PROPOSAL

October 4, 2011

Advisory Engagement for

Greater Waterbury Health Network, Inc.

The Board of Directors ("Board") of Greater Waterbury Health Network, Inc. ("GWHN"), the parent of The Waterbury Hospital (the "Hospital"), is requesting proposals from financial advisory companies to provide a Fairness Evaluation in conjunction with its announced three-way joint venture (the "Transaction") with Saint Mary's Health System, Inc. and LHP Hospital Group, Inc.

Background

On March 4, 2011, GWHN engaged Cain Brothers and Co., LLC ("Cain Brothers") to explore strategic alternatives, which included a partnership, merger or sale. At the Board's direction, Cain Brothers requested proposals from a select group of organizations interested in this type of strategic relationship, with the core objective being the assurance of GWHN's continued long-term vigor as a provider of leading health care services to the Greater Waterbury community. Based on this overarching goal, GWHN evaluated potential partners who could demonstrably help in the achievement of the following objectives:

- Ensure Waterbury Hospital remains a viable health care entity, providing the highest safety and quality health care services to the Greater Waterbury communities for the long-term;
- Deploy repeatable and scalable tools and clinical care services to continually improve the health of the community;
- Provide access to sufficient capital to meet current and future capital needs while strengthening the balance sheet;
- Enhance the Hospital's medical staff by attracting and retaining physicians;
- Maintain high satisfaction scores by patients, physicians, employees and volunteers; and
- Continue charitable care delivery and funding.

After receiving proposals from potential partners, thoughtful diligence and intense negotiations, GWHN announced on August 23, 2011 that it had signed a letter of intent to join with the previously announced joint venture being formed between LHP Hospital Group, Inc. and Saint Mary's Health System, Inc.

The proposed transaction includes a commitment by the joint venture to construct a new medical center facility at a cost of approximately $400 million that will replace both The Waterbury Hospital and Saint Mary's Hospital.

Scope of Work:

Fairness Evaluation. The Transaction will require the Hospital to undertake the conversion process prescribed in Connecticut General Statutes § 19a-486 et seq. (the "Conversion Statute") The Board, to fulfill its fiduciary duties and its obligations under Conversion Statute requires an evaluation as to the appropriateness and fairness of the proposed Transaction. The evaluation must address each of the criteria specified in Connecticut General Statutes § 19a-486(c). The evaluation will be used to support the conclusion that GWHN will receive "fair market value" for its assets, which means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

The Board will utilize the Fairness Evaluation in the conversion process and it will be submitted as part of the Hospital's conversion application. Recognizing that the transaction conveys no cash consideration to GWHN at close, the valuation methodology must reference the intangible value to the Greater Waterbury community of maintaining the mission of GWHN and the value of the commitment of a replacement facility. The evaluation should include an assessment of the management agreement that the Joint Venture will enter into with an LHP affiliate to manage the hospitals' operations. Extrapolation of valuations from for-profit versus not-for-profit organizations and academic hospital systems versus community hospital systems are a requirement. The engagement is self-contained with a single work product.

Terms of Engagement

1. Remuneration: The Board will pay a fixed price for the Fairness Evaluation.

2. Exclusivity: In order to assure independence and avoidance of conflicts of interest, the advisor agrees not to perform or be contracted for any investment banking services for LHP Group, Saint Mary's or any patient care organization operating within 35 miles of GWHN for a period commencing at the time of engagement until the delivery of the Fairness Evaluation.

3. Non-Solicitation: The Board's primary motivation in entering into this agreement is to ensure that a Replacement Hospital is developed by the joint venture, thereby ensuring the highest quality care and delivery system is maintained in the Greater Waterbury Community. The greatest risk to GWHN as an enterprise would be for this transaction to fail to be consummated for any reason. The advisor must, therefore, be cognizant and become fluent in the confidentiality and exclusivity provisions in the Transaction, which essentially prohibit solicitation of any market contact as to any potential transaction or financing involving GWHN.

4. Acknowledgement: The advisor acknowledges that Cain Brothers is GWHN's investment banker, and no other investment banking services are required at this time.

Request for Proposal:

Please provide the Board four (4) sets of the following, in written format, no later than October 14, 2011.

- Firm Overview and Relevant Experience
- Biographies and Commitment of Proposed Team Members
- Diligence Needs
- Process Timeline
- Outline of Other Logistics & Coordination
- Compensation Structure
- Confirmation of Absence of any Conflicts of Interest

Direct your proposal to:

GREATER WATERBURY HEALTH NETWORK, INC.

64 Robbins Street

Waterbury CT 06708

Attention: Darlene Stromstad

EXHIBIT Q7-2

2011 RESPONSE FROM PRINCIPLE VALUATION, LLC TO GWHN REQUEST FOR PROPOSAL

RESPONSE TO RFP

FOR

FAIRNESS EVALUATION FOR CONVERSION OF GREATER WATERBURY HEALTH NETWORK, INC.

SUBMITTED TO:
GREATER WATERBURY HEALTH NETWORK, INC.
ATTENTION: MS. DARLENE STROMSTAD, FACHE
PRESIDENT/CEO
64 ROBBINS STREET
WATERBURY, CONNECTICUT 06708

Principle Valuation, LLC

PEOPLE AND VALUES YOU CAN TRUST

October 13, 2011

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Attention: Ms. Darlene Stromstad, FACHE
President/CEO

Re: Fairness Evaluation for Conversion of Greater Waterbury Health Network, Inc.

This letter serves as our proposal to provide the Board of Directors of Greater Waterbury Heath Network, Inc ("Board", or "GWHN") a Fairness Evaluation in conjunction with its announced three-way joint venture (the "Transaction") with St. Mary's Health System, Inc. and LHP Hospital Group, Inc.

PURPOSE AND BACKGROUND

We understand that the purpose of our analysis will be to provide the Board a fairness evaluation of the Transaction in order for the Board to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute t19a-486 et seq. ("Conversion Statute").

SCOPE

In determining whether the consideration is fair from a financial point of view, we will specifically address the following valuation issues and considerations:

- Assess the "Fair Market Value" of the assets to be transferred by GWHN
- Assess the intangible value to the Greater Waterbury community of maintaining the of GWHN
- Assess the value from a financial point of view of the commitment to build a replacement facility
- Assess from a financial point of view the value of the management agreement that the joint venture will enter into with an LHP affiliate to manage the hospital's operations

In conducting these assessments the following considerations will be made:

- Review the terms associated with the Transaction

- Conduct a site visit to the Hospital to accurately describe and assess the condition of the assets to be transferred
- Review the historical and earning potential of the operating assets that GWHN intends to transfer
- Review and analyze the terms associated with the Management Agreement to be entered into with an affiliate of LHP
- Review the plans, budgets, and financial projections associated with the replacement facility
- Consider the overall market potential of the Waterbury Hospital and the combined joint venture separately and as combined
- Review and analyze other pertinent and necessary information necessary to arrive at our final opinions
- Review and extrapolate transactions that involved for-profit versus non-for-profit organizations and academic hospital systems versus community hospital systems

Fair Market Value for the purposes of this analysis will be defined as follows:

> The most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

PRINCIPLE VALUATION FIRM OVERVIEW, RELEVANT EXPERIENCE, AND TEAM MEMBERS

In 2007, Timothy Baker and David Felsenthal combined their 75 years of healthcare appraisal experience to form Principle Valuation, a firm dedicated to service the specialized needs of the healthcare community. In 2009, Patrick Simers joined as a Principal in the firm and added to the strength of the overall hospital valuation core with more than 25 years in the appraisal of Healthcare properties. All of the Principals of Principle Valuation,("PV" and "Principle"), have served as Presidents and Vice Presidents of many of the major healthcare valuation and healthcare consulting providers including Huron Consulting, American Appraisal, CBIZ, and Valuation Counselors, a valuation firm that Mr. Felsenthal had previously founded which was once recognized as the premier healthcare valuation firm in the industry. From inception our staff has continued to expand and we now have more than seventeen professional employees dedicated to the valuation of healthcare related entities.

Our business is generally segmented into three primary sectors; Hospital and Healthcare Enterprise Related Services, Healthcare Advisory Services; and Senior Housing Related Services.

In the Hospital and Healthcare Related services group, the primary emphasis is to prepare valuations to meet the regulatory guidelines associated with hospital transactions including Stark compliance, State Regulatory Requirements and Purchase Accounting. Valuations conducted in this sector generally include the valuation of hospitals and hospital systems, medical practices, joint ventures valuations, service agreements and other types of healthcare business arrangements. Another major focus of this group is the valuation of tangible and intangible assets associated with purchase accounting for Acute and Specialty Hospitals. Professionals in this group have real estate, medical equipment, and business enterprise expertise.

The Healthcare Advisory Services group is primarily responsible for the preparation of cost segregation studies, facility live analysis, and asset inventory and reconciliation reports. This group's personnel consists of staff members with engineering and tax expertise that assist our clients in reducing their overall tax liability and developing accurate property records that help our clients increase their overall bond ratings. Our Senior Housing Group focuses on the service needs of the senior housing industry. This group prepares market studies and valuations of nursing homes and assisted living residences. Their work is generally presented for financing and utilized to obtain conventional financing and through the HUD 232 program. Professionals in this group include real estate professionals who have detailed knowledge of the regulatory rules and reimbursement policies that dictate the seniors housing industry.

Particularly relevant engagements include fairness reviews and appraisals presented to comply with the Attorney General requirements in Georgia, Mississippi, Louisiana, Florida, Pennsylvania, and New Jersey. Direct hospital transfer assessments included Banks-Jackson-Commerce Hospital in Georgia; Baptist Memorial Hospital – North Mississippi in Mississippi; Ville Platte Medical Center and West Carroll Memorial Hospital in Louisiana; South Shore Hospital in Miami, Florida; and UPMC in Pittsburgh, Pennsylvania. We also recently assessed a hospital management agreement for Meadowlands Hospital Medical Center in New Jersey.

The primary parties that will be active in this engagement include Tim Baker, Patrick Simers, John Leary, and Mary Jo Duffy. As demonstrated by their Qualifications, each member of the team has more than 25 years in the valuation of healthcare enterprises and includes individuals with General Appraiser State Certifications, CFA's, and CPA's. These qualifications are included in the Addenda of this proposal.

DUE DILIGENCE DATA REQUIREMENTS

The following information will be initially and primarily required in order to complete the assignment:

- A Central Contact that is familiar with the overall operations and contemplated transaction. This person will serve as our primary contact and should be able to discuss the financial, and market environment for the assets under consideration. Further this person should have the ability to coordinate site visits with our staff with the Hospital
- Audited Financial Statements of GWHN and its primary operating units for the past three years along with the current year-to-date operations and budgets.
- Forecasted operations for the next three-five year period for Waterbury Hospital operations
- A current Balance Sheet of the Organization and an explanation of which assets are anticipated to transfer
- A copy of the current fixed asset ledger of the Hospital and its associated entities in an excel format
- A listing of all real estate property anticipated to transfer with the transaction; including the address of the property, a brief description of the improvements including its size and use, its associated tax parcel number, and the size of the underlying land parcel
- A copy of any Board Minutes that discussed the contemplated Transaction
- A copy of any reports or presentations that Cain Brother's prepared in making its overall recommendations to the Board
- A copy of the Medicare Cost Reports for the prior two fiscal periods
- A non-redacted version of the CON Application that St. Mary's and LHP provided to the State
- The Current Plans, Budgets, and Forecasted Financials for the Replacement Facility
- A copy of the Management Agreement anticipated between GWHN and LHP
- A Contact at LHP that we can discuss their overall business operations, history, capital resources, financials, etc.
- The Management and Organizational Structure associated with the Joint Venture
- Any Demographic, Market Research, or Competitive Surveys that were conducted to support the overall merger
- A brief write-up of the subject's current ownership and operational history
- Any other data that you feel is necessary that enhances our understanding of the Transaction

PROCESS TIMELINE, LOGISTICS, AND COORDINATION

We would anticipate the following general time line which would lead to an overall engagement completion by November 30, 2011.

- First Week (Oct. 21) — Award of contract and receipt of data requested
- Second Week (Oct. 28) — In-house review of data received and prepare plan for on-site visit to be conducted in the third week
- Third Week (Nov. 4) — Conduct on site visit October 31-November 3 This will primarily consist of a time spent verifying asset lists and getting descriptive data on improvements
- Fourth Week (Nov. 11) — In-Office Pricing, Research, and Development of Preliminary Estimates
- Fifth Week (Nov. 17) — Presentation of Preliminary Findings and Draft Report Development
- Sixth Week (Nov. 25) — Client Review of Draft Report (Thanksgiving Week)
- Seventh Week (Nov. 30) — Adjustments and Development of Final Report

We believe that this time line is reasonable based upon the overall effort and personnel that would be involved in this analysis. Should a tighter time frame be needed, we may be able to accommodate. All time estimates assume that all data requests are promptly received on an ongoing basis throughout the engagement process. We would immediately notify you should any delays in the receipt of information or other items beyond our control would push back these delivery timelines.

CONFIRMATION OF ABSENCE OF ANY CONFLICTS OF INTEREST

Neither Principle Valuation nor its staff members have any known conflict of interest with the parties to this Transaction or to the Transaction itself.

COMPENSATION STRUCTURE

Our fee for this engagement will be [redacted] inclusive of all expenses. We ask that a retainer of [redacted] be issued upon acceptance of this letter. We will subsequently bill [redacted] upon presentation of our initial findings and draft report. We anticipate all payments to be current prior to issuing our final report. Our final invoice, [redacted] will accompany our final report; or if no final report is desired, upon your indication that no final report is required. Our fee is in no way contingent upon the outcome of our conclusions. This fee is based on our estimate of professional services to be furnished, according to our understanding of your requirements; should the scope of these requirements change, Principle Valuation and Greater Waterbury Health Network, Inc. will mutually revise the fee to reflect those changes in services.

Fees include professional time for planning and executing the work through, and including, our final report. Should you require additional consultation based on your reviews of our work or those of your external auditors or your tax or other advisors, or any public presentation, testimony and appearance in front of any tribunal, agency or other body, subsequent payment will be required and we will bill for those services at our prevailing hourly rate for the personnel involved.

We reserve the right to withhold delivery of our preliminary conclusions or final report(s) if, when either of these is ready for delivery, any previously issued invoice remains unpaid. We reserve the right to issue interim or final invoices, as appropriate, should you delay the project and/or in the event that our preliminary or draft report has been in your possession for more than 30 days.

You have the right to terminate this assignment at any time, in which case there will be no further obligation on the part of either party to continue. In such event, you will be obligated to pay only for the actual time and charges accumulated through the date of cessation.

GWHN agrees to indemnify and hold harmless Principle Valuation, its employees, and representatives, collectively ("Principle") from and against any and all losses, claims, damages, or liabilities, joint or several, including all reasonable out-of-pocket expenses, fees, and disbursements of counsel incurred by Principle in defending any claim, action, or proceeding whether or not resulting in a liability to Principle to which they may become subject, caused by, arising out of or in connection with this engagement, including but not limited to, losses, claims, damages or liabilities caused by or arising out of any untrue statements of material fact contained in the information provided to Principle by GWHN or its advisors in connection with our engagement, or any omission to state any therein any material fact required or necessary to make the information not misleading in light of circumstances under which given, or any violation of the federal securities laws or the securities laws of any state, or otherwise arising out of our engagement hereunder except in respect to any matter as to which Principle shall have been adjudicated to have acted with gross negligence or willful malfeasance.

ACKNOWLEDGEMENT

We appreciate this opportunity to provide our recommendations for valuation-consulting services. We are uniquely qualified to perform this assignment, by virtue of our independence, experience, reputation, and expertise. We are committed to completing the work in an efficient and timely manner.

Due to the complexity of the assignment; if any of the terms, as highlighted, need to be discussed or refined please do not hesitate to call us as we would appreciate the opportunity to work with you on this important assignment.
But, if the content of this document correctly reflects your understanding of our agreement, please sign below and return the executed document and return the enclosed copy. This agreement shall remain open and valid for signature for 90 days from the issue date; however, any significant delay in executing this agreement could adversely impact our ability to meet the delivery commitments described herein. Please note we will be unable to start this engagement until we are in receipt of this signed acknowledgment. To avoid any delays in delivery, please

fax the signed acknowledgment to (312) 422-1515. Thereafter, please forward the original to us.

If you have any questions or comments, please call me at (770) 924-8811.

Respectfully submitted,

PRINCIPLE VALUATION, LLC

Patrick J. Simers
PJS/ms

CLIENT: GREATER WATERBURY HEALTH NETWORK, INC.

SIGNATURE(S): _____

NAME (PRINT OR TYPE): _____

TITLE: _____

DATE: _____

PHONE: _____

EXHIBITS

TIMOTHY H. BAKER
PRESIDENT

EXPERIENCE

Mr. Baker has been in the appraisal industry since 1981 with a concentration on healthcare and senior living properties. His valuation experience includes valuing the business enterprise, real estate, and personal property. Valuations have been performed on a national and international basis. Consulting engagements include market and financial feasibility studies.

Mr. Baker has experience in the valuation of numerous healthcare facilities including acute care, behavioral health, and rehabilitation hospitals. Senior living properties include nursing homes, assisted living facilities, and retirement centers. Other related operations include research facilities, healthcare leasing companies, physician practices, and medical office buildings. Mr. Baker has also provided consultations on market assessment, demand analysis, reimbursement issues, development of fixed asset records, and provided analysis of strategic opportunities. Valuation reports prepared by Mr. Baker have been used for several purposes including public offerings, litigation support, HUD 232 and 242 mortgage insurance programs, acquisition/divestitures, property tax purposes, state reimbursement, estate planning, and for internal management decision making.

PROFESSIONAL HISTORY

- 2007 to present – President, Principle Valuation, LLC.
- 2001 to 2007 - Senior Vice President, Wellspring Valuation, Ltd.
- 1997 to 2001 - Vice President, Marshall & Stevens National Healthcare Practice.
- 1992 to 1997 - Senior Manager, Capital Valuation Group, specializing in the valuation of the business and real estate of senior living and healthcare related facilities.
- 1981 to 1992 – Manager, Valuation Counselors where he was responsible for performing a multitude of appraisal and consulting services for clients specializing in business enterprise, real estate, and machinery and equipment.

PROFESSIONAL AFFILIATIONS

- Advisory Committee Member American Senior Housing Association
- Healthcare Financial Management Association
- American Health Lawyers Association
- Associate Member Appraisal Institute

EDUCATION LICENSES, AND DESIGNATIONS

- 1980 graduate of Bucknell University with a Bachelor of Science in Business Administration
- Certified General Real Estate Appraiser Maryland and New Jersey

TESTIMONY

- Testified as expert witness in California, Colorado, Connecticut, New Hampshire, New Jersey and Pennsylvania

PATRICK J. SIMERS
EXECUTIVE VICE PRESIDENT

EXPERIENCE

Mr. Simers has extensive experience in serving the valuation needs of the health-care industry. He has valued all tangible and intangible assets associated with health-care enterprises, including the capital stock of majority and minority share holdings; medical specialty and physician joint ventures; fee simple, leased fee, and leasehold interests in real estate for hospital systems, stand-alone hospital campuses, and medical office buildings; major and minor movable equipment; certificates of need; contractual agreements; and preferred provider arrangements.

Specific healthcare enterprises appraised include acute care hospital facilities, LTACH hospitals, psychiatric hospitals, rehab hospital facilities, single physician practices, multi-specialty practices, cath labs, diagnostic centers, cardiac care practices, home health agencies, nursing homes, assisted living facilities, and medical office buildings.

Mr. Simers has performed fair market value studies for purchase, sale, or financing; merger and acquisition consulting; negotiation of purchase price; fairness opinions; purchase price allocations; financial reporting; SEC reporting; Medicare regulatory requirements; Safe Harbor requirements; and 501(c)(3) private placement offerings.

PROFESSIONAL HISTORY

Mr. Simers began his appraisal career with Valuation Counselors in 1982 and held various consulting, business development, and management roles, including four years as president of Valuation Counselors, leading up to its merger with CBIZ Inc. Most recently, Mr. Simers has served as the National Director for Healthcare services for American Appraisal Associates where he spear-headed the development of healthcare services for this international appraisal firm.

Patrick J. Simers is Executive Vice President for Principle Valuation. He is responsible for the development and overall business plan for Principle's consulting and appraisal services to for-profit, nonprofit, and public health-care providers. Mr. Simers is located in Principle Valuation's Atlanta office.

PROFESSIONAL AFFILIATIONS

- American Health Lawyers Association
- Healthcare Financial Management Association

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Northern Illinois University with a Bachelor of Science in Finance and Economics
- Graduate of Moraine Valley College with a Associate in Arts in Business Administration
- Certified General Real Estate Appraiser in Georgia

JOHN L. LEARY, CFA

EXPERIENCE

Mr. Leary's hospital transaction experience consists of valuations for hospital acquisition and financing transactions in excess of $1 billion, SFAS 144 impairment studies for acute care hospitals, valuations for relative contributions of hospital operations to newly organized joint ventures, and valuations of certificate of need for new hospital construction.

His ambulatory surgery and diagnostic imaging center experience consists of valuation of surgery centers for hospital physician syndications, initial capitalization of joint venture between major metropolitan medical center and physician owned outpatient surgery center, and recapitalization of a multi-modality diagnostic imaging center owned by a partnership consisting of two medical centers and a radiology group.

Mr. Leary also has managed care experience that consists of an equity valuation of Medicaid Provider Service Network serving 50,000 Medicaid members, a SFAS 141 valuation of tangible and intangible assets for a managed care organization with a market capitalization of approximately $1.3 billion, and a purchase price allocation specialty pharmacy and pharmacy benefit management company totaling $1.5 billion.

Mr. Leary has also performed valuations of dialysis, home health, durable medical equipment, respiratory and infusion therapy operations, and physician practices

PROFESSIONAL HISTORY

- 1989 to 2011 - CBIZ Valuation Group, LLC — Atlanta, GA
  Southeastern Director of Financial Valuation Services
- 1987 – 1989 - Carnegie Securities Corporation — Atlanta, GA
  Vice President
- 1980 – 1987 - Storer Cable Communications — Atlanta, GA
  Regional Controller

EDUCATION AND ACCREDITATIONS

- 1978 – 1980 - Georgia State University — Atlanta, GA
  Masters of Business Administration with a concentration in finance
- 1974 – 1978 - Emory University — Atlanta, GA
  Bachelor of Arts with majors in Economics and Political Science
- Chartered Financial Analyst and Certified Public Accountant (inactive license)

MARY JO DUFFY

EXPERIENCE

Ms. Duffy brings 25 years of accounting, auditing, business valuation, business consulting and financial management to her clients. She has testified as an expert witness in deposition and trial, and advised clients on strategy, transactions and general business issues in addition to valuation issues

Ms. Duffy began her career with KPMG as an accountant and auditor. As CEO of Valuation Counselors, a national valuation firm, she provided valuation services to entities as diverse as boat manufacturers, grocery chains, technology ventures and healthcare providers. She served as a partner in a national CPA firm, responsible for appraisal and valuation services nationwide and was a member of the firm's Management Council.

As National Director of Financial Services to the healthcare industry for Coopers & Lybrand L.L.P., a predecessor firm of PricewaterhouseCoopers, Ms. Duffy was responsible for litigation, valuation, merger & acquisition, reorganization and other services to healthcare entities and assisted healthcare clients with matters involving providers, payers and related organizations. She later joined Ernst & Young's Healthcare Consulting practice specializing in physician networks, operations improvement, M&A strategy and post-merger integration. Her expertise in the healthcare arena includes advising providers on strategic options, negotiating transactions and assisting a Debtor in Possession in disposing of the assets, preparing a physician organization for doubling in size and an IPO, and developing integrated networks in academic medical centers and community delivery systems. She has also been the CFO of multi-specialty, multi-site healthcare provider.

PROFESSIONAL HISTORY

- Director, Acuitas, Inc.
- National Director of Financial Services, Coopers & Lybrand
- CEO, Valuation Counselors
- Consultant, Ernst & Young Healthcare Consulting
- Certified Public Accountant and Auditor, KPMG.

PROFESSIONAL AFFILIATIONS

- Leadership Team Member Healthcare Task Force of GSCPAS
- Serves as Board Member for: Turning Point Women's Healthcare, The Childhood Autism Foundation and Emory Austin Resource Center
- Member, Illinois CPA Society
- Officer, Georgia Society of CPAS – Atlanta Chapter

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Georgetown University School of Business
- Certified Public Accountant

HONORABLE DESIGNATIONS

- Honored by Atlanta Magazine as one of Atlanta's outstanding business women.

HEALTHCARE SYSTEMS AND HOSPITALS
OUR PROFESSIONALS HAVE SERVICED SINCE 2000

HEALTHCARE SYSTEMS:	CITY	ST
Advocate Health Care	Oak Brook	IL
Ascension Health	St. Louis	MO
Aurora Health Care	Milwaukee	WI
Banner Health Systems	Phoenix	AZ
Baptist Health South Florida	Coral Gables	FL
Baylor Health Care System	Dallas	TX
Benefis Health System	Great Falls	MT
Capella Healthcare	Franklin	TN
Catholic Health East	Newtown Square	PA
Centura Health	Englewood	CO
CHRISTUS Health	Irving	TX
Community Health Systems, Inc.	Brentwood	TN
Community Memorial Health System	Ventura	CA
Daughters of Charity Health System	Los Altos Hills	CA
Elmhurst Memorial Healthcare	Elmhurst	IL
Envision Corp.	Scottsdale	AZ
Essent Healthcare Inc.	Nashville	TN
Gulf States Health Services	Baton Rouge	LA
Health Care REIT, Inc.	Toledo	OH
Health East	Minneapolis	MN
Health Management Associates	Naples	FL
Holistic Health Care, Inc.	Birmingham	AL
Hospital Sisters Health System	Springfield	IL
Ingalls Health System	Harvey	IL
Jewish Hospital & St. Mary's Healthcare	Louisville	KY
Landmark Hospitals	Cape Girardeau	MO
LifeCare Management Service	Plano	TX
LifePoint Hospitals, Inc.	Brentwood	TN
Memorial Healthcare System	Hollywood	FL
NorthShore University Health System	Evanston	IL
Presbyterian Healthcare Services	Albuquerque	NM
Provena Health	Chicago	IL
Rapid City Regional Hospital	Rapid City	SD
Renaissance Healthcare Systems	Houston	TX
Resurrection Health Care	Chicago	IL
Saint Barnabas Health System	Livingston	NJ

HEALTHCARE SYSTEMS:	CITY	ST
Saint Thomas Health Services	Nashville	TN
Sarasota Memorial Healthcare System	Sarasota	FL
Seton Family of Hospitals	Austin	TX
Sisters of St. Francis Health Services	Mishawaka	IN
Specialty Hospitals of America, LLC	Portsmouth	NH
SSM Regional Health Services/St Mary's Health Center	Jefferson City	MO
St. Anthony Memorial Health Centers	Michigan City	IN
St. Francis Health System	Pittsburgh	PA
St. Vincent's Health System	Birmingham	AL
Summa Health Systems	Akron	OH
Trinity Health	Novi	MI
Universal Health Services	King of Prussia	PA
University Hospital Health System - Cleveland	Cleveland	OH
University Hospital Health System - San Antonio	San Antonio	TX
Vanguard Health Systems	Nashville	TN
Vibra Healthcare	Mechanicsburg	PA

HOSPITALS:	CITY	ST
Carraway Burdick West Medical Center	Haleyville	AL
Carraway Northwest Medical Center	Winfield	AL
Crestwood Medical Center	Huntsville	AL
Hartselle Medical Center	Hartselle	AL
Parkway Medical Center	Decatur	AL
Russellville Hospital	Russellville	AL
Southern Cancer Center	Mobile	AL
Harris Hospital	Newport	AR
Helena Regional Medical Center	Helena	AR
National Park Medical Center	Hot Springs	AR
North Metro Medical Center	Jacksonville	AR
Siloam Springs Memorial Hospital	Siloam Springs	AR
St. Mary's Regional Medical Center	Russellville	AR
Holy Cross Hospital	Nogales	AZ
Plaza del Rio Campus	Sun City	AZ
St. Joseph Hospital	Tucson	AZ
St. Mary's Hospital	Tucson	AZ
Sun Health Del E. Webb Campus	Sun City West	AZ
Tuscan Medical Center	Tucson	AZ
William O. Boswell Hospital	Sun City	AZ
Cedars Sinai Medical Center	Los Angeles	CA

HOSPITALS:	CITY	ST
Community Hospital of the Monterey Peninsula	Monterey	CA
Downey Regional Medical Center	Downey	CA
Hemet Valley Medical Center	Hemet	CA
Hollywood Presbyterian Medical Center	Los Angeles	CA
Kentfield Rehabilitation & Specialty Hospital	Kentfield	CA
Lancaster General Hospital	Lancaster	CA
Menifee Valley Medical Center	Sun City	CA
Norris Comprehensive Cancer Center & Hospital	Los Angeles	CA
Parkview Community Hospital	Riverside	CA
Physicians' Hospital of Rancho California	Murrieta	CA
Robert H. Ballard Rehabilitation Hospital	San Bernardino	CA
San Joaquin Valley Rehabilitation Hospital	Fresno	CA
USC University Hospital	Los Angeles	CA
Ventura Hospital	Ventura	CA
Lutheran Campus ASC LLC	Wheat Ridge	CO
OrthoColorado Hospital	Lakewood	CO
Penrose Hospital	Colorado Springs	CO
St. Anthony North Hospital	Westminster	CO
St. Mary-Corwin Medical Center	Pueblo	CO
St. Thomas More Hospital	Canon City	CO
Capital Hills Hospital	Sharon	CT
Greenwich Hospital	Greenwich	CT
Sharon Hospital	Sharon	CT
Greater Southeast Community Hospital	Washington	DC
Providence Hospital	Washington	DC
Specialty Hospital of Washington-Hadley	Washington	DC
Boca Raton Community Hospital	Miami	FL
Baptist Hospitals of Miami	Miami	FL
Bonita Community Health Center	Boca Raton	FL
East Point Hospital	Bonita Springs	FL
Fishermen's Hospital	Marathon	FL
Health Central Hospital	Ocoee	FL
HealthSouth Ridgelake Hospital	Sarasota	FL
Holy Cross Hospital	Marathon	FL
Homestead Hospital	Fort Lauderdale	FL
Jacksonville Medical Center	Homestead	FL
Mercy Hospital	Miami	FL
Memorial Hospital Pembroke	Jacksonville	FL
Memorial Hospital of South Broward	Pembroke Pines	FL

HOSPITALS:	CITY	ST
Memorial Regional Hospital	Hollywood	FL
Northwest Florida Community Hospital	Chipley	FL
Park Royal Hospital	Ft. Myers	FL
Santa Rosa Medical Center	Milton	FL
Shands Lake Shore	Lake City	FL
Shands Live Oak	Live Oak	FL
Shands Starke	Starke	FL
West Kendell Baptist Hospital	Kendell	FL
Wuesthoff Medical Center-Rockledge	Rockledge	FL
Wuesthoff Medical Center-Melbourne	Melbourne	FL
Athens Long-Term Acute Care Hospital	Athens	GA
Banks-Jackson-Commerce Hospital and Nursing Home	Atlanta	GA
Grady Memorial Hospital	Atlanta	GA
Hamilton Medical Center	Dalton	GA
Complex Care Hospital of Idaho	Meridian	ID
Advocate Bethany Hospital	Chicago	IL
Advocate BroMenn Regional Medical Center	Normal	IL
Advocate Christ Medical Center	Oak Lawn	IL
Advocate Condell Medical Center	Libertyville	IL
Advocate Good Samaritan Center	Downers Grove	IL
Advocate Illinois Masonic Medical Center	Chicago	IL
Advocate Lutheran General Hospital	Park Ridge	IL
Advocate South Suburban Hospital	Hazel Crest	IL
Elmhurst Memorial Hospital	Elmhurst	IL
Evanston Northwestern Health Care	Evanston	IL
Good Shepherd Hospital	Barrington	IL
Gottlieb Memorial Hospital	Melrose Park	IL
Holy Family Medical Center	Des Plaines	IL
Marshall Browning Hospital	DuQuoin	IL
Mercy Hospital & Medical Center	Chicago	IL
Northwest Community Hospital	Arlington Heights	IL
Our Lady of Resurrection Medical Center	Chicago	IL
Palos Community Hospital	Palos Heights	IL
Provena St. Joseph Hospital	Elgin	IL
Provena St. Mary Hospital	Aurora	IL
Resurrection Medical Center	Chicago	IL
Rockford Memorial Hospital	Rockford	IL
Rush-Copley Medical Center	Aurora	IL
Rush University Medical Center	Chicago	IL

HOSPITALS:	CITY	ST
Saint Anthony Hospital	Chicago	IL
Saint Joseph's Medical Center	Joliet	IL
Sherman Hospital	Elgin	IL
St. Anthony's Memorial Hospital	Effingham	IL
St. Elizabeth Hospital	Chicago	IL
St. Elizabeth Medical Center	Granite City	IL
St. Francis Hospital	Evanston	IL
St. James Hospital & Health Center	Chicago Heights	IL
St. John's Hospital	Springfield	IL
St. Joseph Hospital	Chicago	IL
St. Mary's Hospital	Decatur	IL
St. Mary's Hospital	Kankakee	IL
St. Mary's Hospital	Streator	IL
St. Mary of Nazareth Hospital	Chicago	IL
Swedish American Hospital	Rockford	IL
The Hospital for Specialty Care	Chicago	IL
Bluffton Regional Medical Center	Bluffton	IN
Dukes Memorial Hospital	Peru	IN
DuPont Hospital	Fort Wayne	IN
Elkhart General Hospital	Elkhart	IN
Franciscan Point Saint Anthony Health Complex	Crown Point	IN
Franciscan Physician Hospital	Munster	IN
Heartland Memorial Hospital	Munster	IN
Kosciusko Community Hospital	Warsaw	IN
Lutheran Hospital of Indiana	Fort Wayne	IN
Monroe Hospital	Bloomington	IN
Morgan Hospital and Medical Center	Martinsville	IN
OP Pavilion	Dyer	IN
Pinnacle Hospital	Crown Point	IN
Pulaski Memorial Hospital	Winamac	IN
Rehabilitation Hospital of Fort Wayne	Fort Wayne	IN
Starke Memorial Hospital	Knox	IN
St. Anthony Memorial	Michigan City	IN
St. Francis Hospital - Mooresville	Mooresville	IN
St. Francis Hospitals & Health Centers - South Campus	Indianapolis	IN
St. Joseph Hospital	Fort Wayne	IN
St. Joseph Regional Medical Center	Mishawaka	IN
St. Margaret Mercy Hospital	Hammond	IN
St. Vincent Indianapolis Hospital	Indianapolis	IN

HOSPITALS:	CITY	ST
Shawnee Mission Medical Center	Shawnee Mission	KS
Western Plaines Medical Complex	Dodge City	KS
Jewish Hospital	Louisville	KY
Jewish Hospital Shelbyville	Shelbyville	KY
Southern Kentucky Rehabilitation Hospital	Bowling Green	KY
Avoyelles Hospital	Marksville	LA
Baton Rouge General Medical Center	Baton Rouge	LA
CHRISTUS Coushatta Health Care Center	Coushatta	LA
CHRISTUS Schumpert Highland	Shreveport	LA
CHRISTUS Schumpert St. Mary Place	Shreveport	LA
CHRISTUS St. Francis Cabrini Hospital	Alexandria	LA
CHRISTUS St. Patrick Hospital	Lake Charles	LA
HealthSouth Specialty Hospital of North Louisiana	Ruston	LA
Oakdale Community Hospital	Oakdale	LA
Presbyterian Intercommunity Hospital	Lafayette	LA
River West Medical Center	Plaquemine	LA
Sabine Medical Center	Many	LA
Merrimack Valley Hospital	Haverhill	MA
New Bedford Rehabilitation Hospital	New Bedford	MA
Hillsdale Community Health Center	Hillsdale	MI
St. Joseph Mercy Hospital	Ypsilanti	MI
Truvista Surgery Center	Troy	MI
St. Joseph's Hospital	St. Paul	MN
Cape Girardeau Long-Term Acute Care Hospital	Cape Girardeau	MO
Crossroads Regional Hospital	Wentzville	MO
Franciscan Sisters of Our Lady of Perpetual Help of Ohio	St. Louis	MO
Joplin Long-Term Acute Care Hospital	Joplin	MO
Mineral Area Regional Medical Center	Farmington	MO
Northcrest Regional Medical Center	Kirksville	MO
North Kansas City Hospital	North Kansas City	MO
SSM Regional Health Services	Jefferson City	MO
St. Alexius Hospital - Broadway Campus	St. Louis	MO
St. Alexius Hospital - Jefferson Campus	St. Louis	MO
St. Anthony's Medical Center	St. Louis	MO
St. Mary's Health Center	Jefferson City	MO
St. Mary's Hospital of Blue Springs	Blue Springs	MO
Oxford Lafayette Medical Center	Oxford	MS
Marlton Rehabilitation Hospital	Marlton	NJ
Meadowlands Hospital Medical Center	Secaucus	NJ

HOSPITALS:	CITY	ST
Memorial Hospital of Salem County	Salem	NJ
Mountainside Hospital	Montclair	NJ
Muhlenberg Medical Center	Plainfield	NJ
St. Michael's Medical Center	Newark	NJ
Presbyterian Hospital	Albuquerque	NM
Presbyterian North Side Hospital	Albuquerque	NM
HealthSouth Hospital at Tenaya	Las Vegas	NV
Deaconess Center	Buffalo	NY
St. Mary's Hospital	Amsterdam	NY
Brown County Regional Hospital	Georgetown	OH
Conneaut Medical Center	Conneaut	OH
Geneva Medical Center	Geneva	OH
Hillside Rehabilitation Hospital	Warren	OH
Mahoning Valley Hospital	Warren	OH
Mahoning Valley Hospital LTAC	Boardman	OH
Select Specialty Hospital	Akron	OH
St. Thomas Hospital	Akron	OH
Summa Health	Akron	OH
Logan Medical Center	Guthrie	OK
Willamette Valley Medical Center	McMinnville	OR
Chestnut Hill Healthcare	Philadelphia	PA
HealthSouth Hospital of Pittsburgh	Monroeville	PA
HealthSouth Regional Specialty Hospital	Mechanicsburg	PA
Lock Haven Hospital	Lock Haven	PA
Memorial Hospital	Towanda	PA
Mercy Hospital	Scranton	PA
Mercy Special Care Hospital – Nanticoke	Nanticoke	PA
Mercy Tyler Hospital	Tunkhannock	PA
Moses Taylor Hospital	Scranton	PA
Southwest Regional Medical Center	Waynesburg	PA
St. Francis Hospital Cranberry	Cranberry	PA
St. Francis Hospital of New Castle	New Castle	PA
St. Francis Medical Center	Pittsburgh	PA
Lookout Memorial Hospital	Spearfish	SD
Sturgis Community Health Care Center	Sturgis	SD
Baptist Hospital of Cocke County	Newport	TN
Fentress County General Hospital	Jamestown	TN
Gateway Medical Center	Clarksville	TN
Haywood Park Community Hospital	Brownsville	TN

HOSPITALS:	CITY	ST
McKenzie Regional Hospital	McKenzie	TN
Mercy Medical Center North	Powell	TN
Mercy Medical Center St. Mary's	Knoxville	TN
Mercy Medical Center West	Knoxville	TN
Methodist Healthcare McNairy	Selmer	TN
Methodist Healthcare Volunteer Hospital	Martin	TN
Methodist Healthcare-Brownsville	Brownsville	TN
Methodist Healthcare-Dyersburg	Dyersburg	TN
Methodist Healthcare-Jackson	Jackson	TN
Methodist Healthcare-McKenzie	McKenzie	TN
Methodist Healthcare-Lexington	Lexington	TN
Middle Tennessee Medical Center	Murphysboro	TN
North Coast Medical Center	Springfield	TN
St. Mary's Jefferson Memorial Hospital	Jefferson City	TN
St. Mary's Medical Center of Campbell County	LaFollette	TN
St. Mary's Medical Center of Scott County	Oneida	TN
White County Community Hospital	Sparta	TN
Baptist Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Children's Hospital	San Antonio	TX
CHRISTUS Santa Rosa Hospital-City Centre	San Antonio	TX
CHRISTUS Santa Rosa Hospital-Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Hospital-New Braunfels	New Braunfels	TX
CHRISTUS Santa Rosa Hospital-Westover Hills	San Antonio	TX
CHRISTUS Spohn Hospital Alice	Alice	TX
CHRISTUS Spohn Hospital Corpus Christi Memorial	Corpus Christi	TX
CHRISTUS Spohn Hospital Corpus Christi South	Corpus Christi	TX
CHRISTUS Spohn Hospital Kleberg	Kingsville	TX
Dell Children's Medical Center	Austin	TX
East El Paso Physicians' Medical Center	El Paso	TX
Gulf Coast Medical Center	Wharton	TX
HealthSouth Hospital of Houston	Houston	TX
Highland Medical Center	Lubbock	TX
LifeCare Hospitals of Ft. Worth	Ft. Worth	TX
LifeCare Hospitals of Plano	Plano	TX
LifeCare Hospitals of San Antonio	San Antonio	TX
Longview Regional Medical Center	Longview	TX
Medical Center of Mesquite	Mesquite	TX
North Central Baptist Hospital	San Antonio	TX
Northeast Baptist Hospital	San Antonio	TX

HOSPITALS:	CITY	ST
Renaissance Hospital of Groves	Groves	TX
Renaissance Hospital of Dallas	Dallas	TX
Renaissance Hospital of Houston	Houston	TX
San Angelo Community Medical Center	San Angelo	TX
Seton Medical Center Williamson	Round Rock	TX
Southeast Baptist Hospital	San Antonio	TX
South Texas Spine & Surgical Hospital	San Antonio	TX
St. Luke's Baptist Hospital	San Antonio	TX
Texas Specialty Hospital	Houston	TX
Trinity Community Medical Center of Brenham	Brenham	TX
Trinity Medical Center	Carrollton	TX
Jordan Valley	West Jordan	UT
Rocky Mountain Medical Center	Salt Lake City	UT
Lee Community Hospital	Pennington Gap	VA
St. Mary's Hospital	Norton	VA
Empire Health Services	Spokane	WA
Lourdes Medical Center	Pasco	WA
St. Joseph Regional Medical Center	Lewiston	WA
Valley Medical Center	Renton	WA
LifeCare Hospitals of Wisconsin	Pewaukee	WI
Aurora Medical Center Grafton	Grafton	WI
Aurora Medical Center Oshkosh	Oshkosh	WI
Aurora Medical Center Summit	Summit	WI
Sacred Heart Hospital	Eau Claire	WI
St. Joseph's Hospital	Chippewa Falls	WI
St. Mary's Hospital Medical Center	Green Bay	WI
St. Nicolas Hospital	Sheboygan	WI
St. Vincent Hospital	Green Bay	WI
Bluefield Regional Medical Center	Bluefield	WV
Charleston Area Medical Center	Charleston	WV
Thomas Memorial Hospital	South Charleston	WV

EXHIBIT Q7-3

ADDITIONAL RESPONSES TO GWHN REQUEST FOR PROPOSAL

HOULIHAN LOKEY

October 14, 2011

Darlene Stromstad, FACHE
Greater Waterbury Health Network, Inc.
64 Robbins St.
Waterbury, CT 06708

Re: Fairness Opinion Proposal

Dear Ms. Stromstad:

We appreciate your interest in Houlihan Lokey Howard & Zukin ("Houlihan Lokey") and our financial advisory and fairness opinion services. We understand that Greater Waterbury Health Network, Inc. (the "Company") is contemplating a transaction in which the Company would enter into a joint venture (the "Joint Venture") with LHP Hospital Group, Inc. ("LHP") and Saint Mary's Health System, Inc. ("Saint Mary's") to build and operate a new hospital (the "Transaction"). Under proposed terms of the Transaction, LHP would fund the construction of the new hospital with a cost of approximately $400 million and both St. Mary's and LHP would close their existing facilities. We understand that the Company would receive a 10% interest in the Joint Venture operating the hospital and receive no cash consideration. We further understand that LHP would receive an 80% interest in the Joint Venture and St. Mary's would receive a 10% interest.

Houlihan Lokey is an international investment banking firm and is generally acknowledged as the leading M&A fairness opinion advisor in the U.S. The firm is uniquely qualified to provide independent financial advisory services to the Company's Board of Directors (the "Board") as it considers the Transaction. This advisory role is one that Houlihan Lokey has played in several other transactions.

This proposal letter introduces you to Houlihan Lokey and outlines our firm's capabilities and fairness opinion services. We have also provided you under separate cover a Presentation of Qualifications describing our experience in greater detail, including our fairness opinion and healthcare industry credentials, and professional biographies of the individuals who will work on this engagement.

Firm Overview

Houlihan Lokey provides a wide range of advisory services, including mergers and acquisitions, private placements of debt and equity, valuation services including transaction opinions, and financial restructuring. We have over 800 employees located in 14 offices throughout the world, including Los Angeles, New York, Chicago, San Francisco, Dallas, Atlanta, Minneapolis, Washington, D.C., London, Paris, Frankfurt, Hong Kong, Tokyo and Beijing. We annually serve more than 1,000 clients worldwide, ranging from closely held companies to Global 500 corporations. The firm is recognized as one of the leading M&A fairness opinion advisors, consistently ranking as one of the most active firms according to M&A league tables.

Overview of Fairness Opinion Practice

Houlihan Lokey has developed an outstanding reputation in advising on fairness opinions and analyses to boards of directors of both public and private companies, special or independent committees, partnerships, foundations, interested shareholder groups and trustees. According to *Thomson Reuters*, Houlihan Lokey was ranked as the number one M&A fairness opinion advisor over the past ten years in transactions involving U.S. companies. The firm has rendered fairness opinions in every conceivable change of control transaction, including mergers, sales, divestitures and going private transactions. In other contexts, we have rendered fairness opinions for mergers of equals, exchange offers, private placements of public equity ("PIPEs"), down round financings, recapitalizations, sales of securities, and leveraged purchases.

As a financial advisor, Houlihan Lokey brings a broad array of applicable transaction experience to each client it serves and treats each engagement with the strictest confidentiality, as any breach can have a devastating impact on the ultimate purchase price and success of closure. Houlihan Lokey's clients have come to rely on the firm for its technical expertise, unimpeachable credibility and independent posture in all of its opinions. The accompanying Presentation of Qualifications summarizes our expertise and provides an extensive list of representative fairness opinion engagements. These engagements validate our firm's independence, responsiveness, and expertise at rendering opinions, all of which make us the ideal candidate to advise the Board on the fairness of the Transaction.

In assessing the Transaction, we will conduct a comprehensive investigation of the Company, the local healthcare market, the expected operations of the Joint Venture and the economics and benefits of the Transaction. Our due diligence process is very thorough, consisting of interviews of senior and operating management of the Company, interviews with the Transaction advisors, and analysis and review of information provided by the Company and its advisors. We believe our technical capabilities are unmatched, as we conduct rigorous analysis in connection with each of our fairness engagements. Finally, the analysis and conclusions developed by the engagement team culminate with an internal presentation to our Fairness Review Committee, which consists of several senior officers of Houlihan Lokey (excluding any engagement team members). The Fairness Review Committee conducts an extensive review of the fairness analysis prior to the delivery of a fairness opinion and presentation to the Board.

Healthcare Expertise

Houlihan Lokey has a dedicated global team of investment bankers who are focused on the healthcare industry with specific expertise in the hospital management space. The team has extensive expertise and experience in advising on M&A transactions, financial restructurings, and providing counsel for strategic decision making. We have numerous longstanding relationships with board members and executives of both quoted and private companies, in addition to contacts with a broad range of associated investors and lenders. We have included a specific section detailing our healthcare expertise in the Presentation of Qualifications.

Scope of Services and Proposed Fees

The engagement team will interface with the Board and its advisors throughout the engagement, with the Board ultimately receiving a signed fairness opinion, along with a presentation summarizing our analysis and conclusions. The fairness opinion will address the consideration received by the Company in the form of a 10% interest in the Joint Venture. In addition to the fairness opinion, we will address: (1) the

intangible benefit to the Waterbury community of maintaining the mission of the Company and the commitment of a replacement hospital; (2) an assessment of the management agreement to be entered between the Joint Venture and LHP; and (3) a comparison of valuations between for-profit, not-for-profit, academic and community hospital systems.

Although the opinion and analyses are used by the Board to exercise its fiduciary duties and will be included in its filing to the State of Connecticut, we deliver even greater value to the Board in providing the full backing of our firm in the event that there is any subsequent scrutiny by the State Attorney General.

Houlihan Lokey provides its clients with exceptional expertise, senior-level attention and responsive execution. Ben Buettell and Michael DeLuke will be the team leaders for this engagement with significant assistance from Gary Brewster. Ben is a Managing Director and co-head of the firm's Fairness and Solvency Opinion Practice. Michael is a Director in the Financial Advisory Services practice and has significant healthcare experience in the hospital sector. We will be supported by additional professionals from our healthcare practice and others. We believe there is no better-suited engagement team to assist the Board in its deliberations in connection with the Transaction.

Typically, the fees for our services depend upon the nature of the engagement, the perceived risk of the requested opinion, the timing and complexity of the transaction, and the associated staffing requirements. Based on our preliminary understanding of the Transaction, we propose a fee of $300,000. In addition to the professional fees outlined above, Houlihan Lokey would be entitled to the reimbursement of its necessary and reasonable out-of-pocket expenses, including any reasonable fees for outside legal counsel. The fee would be payable by the Company as follows: (i) upon execution of Houlihan Lokey's retainer agreement, a non-refundable payment of [redacted] and (ii) the remainder of the fee upon delivery of our opinion.

Other Requested Information

Houlihan Lokey does not have any conflicts with the parties in the Transaction.

We propose a timeline for the delivery of a draft report of three weeks from the receipt of requested materials and have included a preliminary information list as Attachment A. We believe Company management would have ready access to the majority of items on the list but can work with management as needed to complete our information needs. Our proposed timeline is based on the following:

- Week One – Review of information and initial due diligence
- Week Two – Preparation of valuation and other analyses
- Week Three – Preparation of presentation materials and internal review

Our initial due diligence would include a site visit and discussions with the key financial, strategic and operational team of the Company consisting of four to eight hours. We would also request interview(s) with LHP either telephonically or on-site that might last one to two hours. After initial diligence, we would likely have continued follow-up via telephone or e-mail via the key contact points as designated by the Company.

In Closing

We trust that this proposal and the accompanying presentation set forth our credentials and demonstrate that Houlihan Lokey is uniquely qualified to assist the Board. We look forward to the opportunity to work with you on this important transaction. Please do not hesitate to contact us at your convenience to discuss this proposal.

Regards,

Gary Brewster	Ben Buettell	Michael DeLuke
Managing Director	Managing Director	Director

cc: Ann H. Zucker, Carmody & Torrance LLP

Attachment A

Greater Waterbury Health Network
Diligence Needs

While we realize that you may not be able to provide us with all the information that has been listed, this request should serve as guidance for developing the information we will need for the successful completion of the analysis. If you have any questions regarding the items on the list, please contact Michael DeLuke at 214-220-8487.

1. Audited fiscal year financial statements (i.e., balance sheet, income statement, and statement of cash flows) for the prior three years. Please provide historical financials in internal management-style reports formatted to include gross revenues by inpatient/outpatient/etc. and detail behind revenue deductions.

2. Latest interim year-to-date financial information with comparison to the same period last year.

3. Operating and statistical utilization information for the prior three years and interim periods above.

4. Operating budgets for the remainder of 2011 and the next 5 years.

5. Details of any non-recurring income or expense items during the prior 3 years.

6. Hospital's most recent business plan including any long-term financial or operating projections.

7. Estimates of the following (may be included in business plan):
    a. Net revenue growth expected for the next five years
    b. Operating and non-operating expense growth
    c. Any estimates on long-term expected utilization, occupancy, FTE levels, etc.
    d. Expectations of growth or changes in services (outpatient, home health, ER, etc.)
    e. Expectations and impacts of changes in mix of beds, services, etc.

8. Information memorandum or other information prepared by Cain Brothers during the prior sales process.

9. Signed letter of intent and draft formation/operating agreements regarding the joint venture.

10. When available, draft management agreement between the joint venture and LHP.

11. Details and status of any ongoing capital projects at the facilities.

12. Comments on any physical plant limitations or functional constraints on the delivery of services.

13. Most recently compiled economic and demographic information for the market service area.

14. Comments on physician relations, retention, recruitment, etc. (may be included in business plan).

15. Details on any non-operating assets such as restricted cash/securities or undeveloped land.

16. If applicable, a summary of any outstanding contingencies, liabilities, litigation, etc. not described in the financial data provided. This includes detail of any non-normal amounts receivable or payable to Medicare and other fiscal intermediaries.

Greater Waterbury Health Network | October 2011

Presentation of Qualifications

Confidential

HOULIHAN LOKEY

www.HL.com U.S. 800.788.5300 Europe +44.20.7839.3355 Hong Kong +852.3551.2300 Japan +81.3.4577.6000

Los Angeles • New York • Chicago • San Francisco • Minneapolis • Washington, D.C. • Dallas • Atlanta • London • Paris • Frankfurt • Hong Kong • Tokyo • Beijing

Greater Waterbury Health Network

Table of Contents

Houlihan Lokey Overview

Houlihan Lokey Overview

A Leading Investment Banking Firm

HOULIHAN LOKEY

Corporate Finance

Mergers and Acquisitions

- Sellside & Buyside Transactions
- Leveraged Transactions
- Minority Equity Transactions

Capital Markets

- Debt & Equity Private Placements
- High Yield
- PIPEs Financings
- Liabilities Management
- Special Situations Advisory

Financial Advisory

- Fairness Opinions
- Solvency Opinions
- Valuation Opinions
- Transaction Advisory Services
- Tax & Financial Reporting Valuation
- Portfolio Valuation & Advisory Services
- Derivatives Valuation & Advisory Services
- Dispute Resolution & Financial Expert Opinions

Financial Restructuring

- Chapter 11 Planning
- Restructuring Debt and Equity
- Debtor-in-Possession ("DIP") Financing
- Exchange Offers
- Plans of Reorganization
- Distressed Mergers and Acquisitions

Ranked Among Top 10 M&A Advisors for Ten Straight Years

2010 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	117
2	Goldman Sachs & Co	99
3	Lazard	82
4	Bank of America Merrill Lynch	77
5	JP Morgan	73

Source: Thomson Reuters

M&A Advisor's 2010 Valuation Firm of the Year

M&A Fairness Advisory Rankings
Announced or Completed Deals – 2001 to 2010

Rank	Advisor	Number of Deals
1	Houlihan Lokey	642
2	JP Morgan	516
3	Bank of America Merrill Lynch	368
4	Morgan Stanley	323
5	UBS	304

Source: Thomson Reuters

No. 1 Investment Banking Restructuring Advisor

Global Distressed Debt & Bankruptcy Restructuring Rankings 2010

Rank	Advisor	Number of Deals
1	Houlihan Lokey	74
2	Lazard	58
3	Rothschild	50
4	Moelis & Co.	28
5	Blackstone Group LP	25

Source: Thomson Reuters, January 2011.

Recent Highlights and Accomplishments

Closed More Middle-Market Deals Than Any Other Firm

2010

2010 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	117
2	Goldman Sachs & Co	99
3	Lazard	82
4	Bank of America Merrill Lynch	77
5	JPMorgan	73
6	Jefferies & Co Inc	72
7	Morgan Stanley	59
8	Credit Suisse	57
9	Barclays Capital	56
10	RBC Capital Markets	53

Source: Thomson Reuters.

2009

2009 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	71
2	Goldman Sachs & Co	57
3	Bank of America Merrill Lynch	55
4	JP Morgan	53
5	Lazard	51
6 *	Credit Suisse	50
6 *	Morgan Stanley	50
8	UBS	40
9	RBC Capital Markets	38
10 *	Citi	36
10 *	Deutsche Bank AG	36

* denotes tie.
Source: Thomson Reuters.

2008

2008 M&A Advisory Rankings
U.S. Transactions Under $1 Billion

Rank	Advisor	Number of Deals
1	Houlihan Lokey	112
2	Goldman Sachs & Co	87
3	JPMorgan	85
4	Credit Suisse	78
5	Merrill Lynch	62
6 *	Morgan Stanley	61
7 *	Lazard	59
7 *	UBS	59
9	Citi	57
10	Jefferies & Co Inc	56

* denotes tie.
Source: Thomson Reuters.

2007

2007 M&A Advisory Rankings
U.S. Deals Under $1 Billion

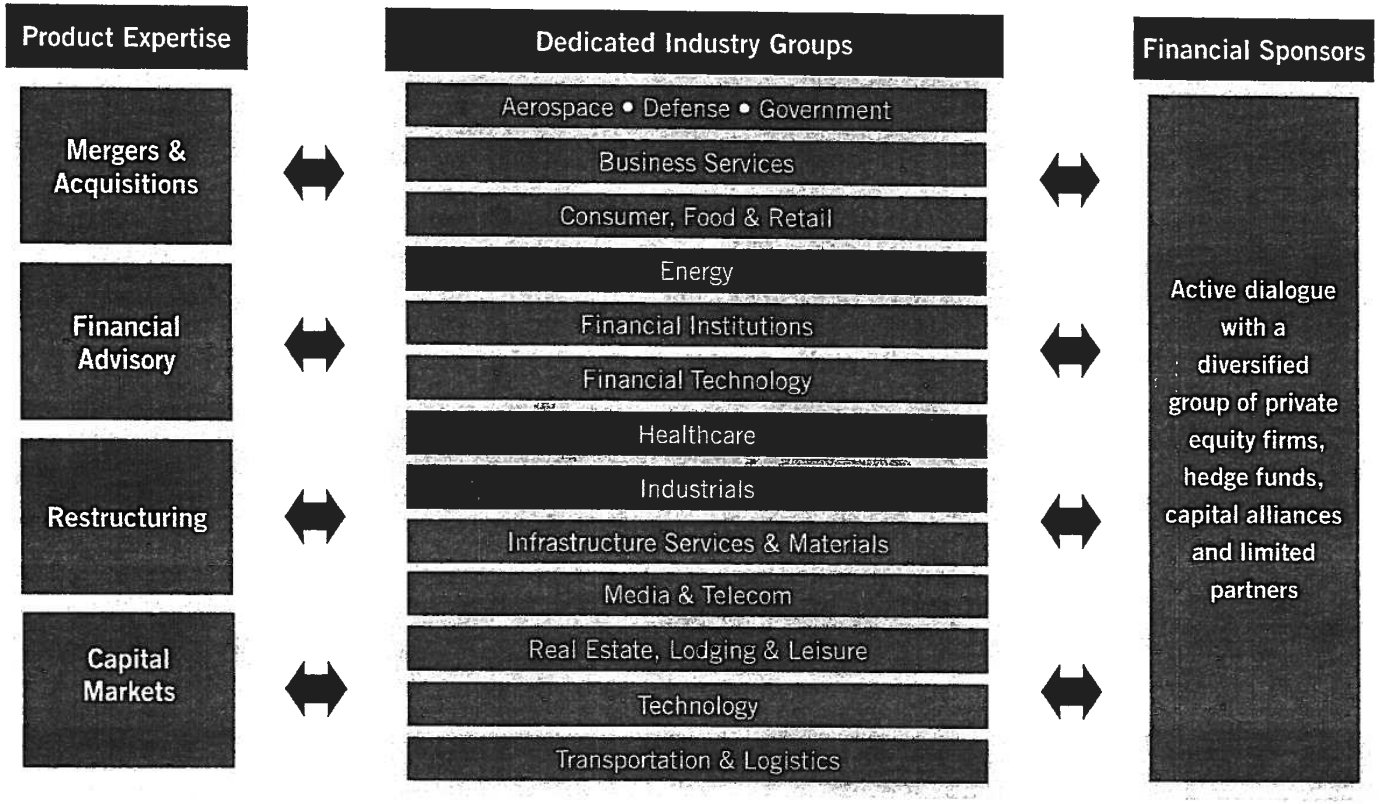
Rank	Advisor	Number of Deals
1	Houlihan Lokey	122
2	Credit Suisse	112
3	Goldman Sachs & Co	102
3 *	Citi	102
5	Jefferies & Co Inc	92
6	UBS	88
7	Lehman Brothers	87
7 *	JP Morgan	87
9	Morgan Stanley	74
10	RBC Capital Markets	71

* denotes tie.
Source: Thomson Financial.

Winner of Numerous Industry Awards

- 2010 Mid Market Bank of the Year
  Investment Dealers' Digest
  - Awarded by Investor's Dealers Digest on January 28, 2011
- 2010 Mid-market Financial Advisor of the Year – United States
  - Awarded by Financial Times and Mergermarket on December 13, 2010
- 2010 Investment Bank of the Year – North America
  - Awarded by InterContinental Finance Magazine on September 20, 2010
- 2009 Investment Banking Firm of the Year
  - Awarded by M&A Advisor on December 14, 2009

Fully Integrated Industry, Product and Private Equity Capabilities



Strategic Global Presence

- Houlihan Lokey has over 800 employees in 14 offices worldwide
- With three offices in Europe and three offices in Asia, Houlihan Lokey has the global reach and local country presence to support international transactions
- In 2005, Houlihan Lokey partnered with ORIX Corporation (NYSE:IX), a leading integrated financial services group, headquartered in Tokyo, Japan
- In 2010, Houlihan Lokey expanded its presence into India and Singapore through a strategic minority investment in the Avista Advisory Group, a 25-person investment banking firm headquartered in Mumbai

Fairness Opinion Services

Fairness Opinion Services

Uniquely Qualified

Experience

No. 1 M&A Fairness Opinion Advisor

Attributes of Large Firm

- Global reach – presence in United States, Europe and Asia
- Dedicated industry groups and product specialists
- Credibility with and access to acquisition candidates
- Financing markets expertise – understanding of public and private financing alternatives

Attributes of Mid-Size Firm

- Proven integrity – private advisory firm with no investment research, underwriting or equity positions
- Comprehensive guidance – creativity and analytical depth; routinely structure complex transactions and achieve compelling results
- Senior level attention – experienced, senior bankers lead all engagements

M&A Fairness Advisory Rankings
Announced or Completed Deals – 2001 to 2010

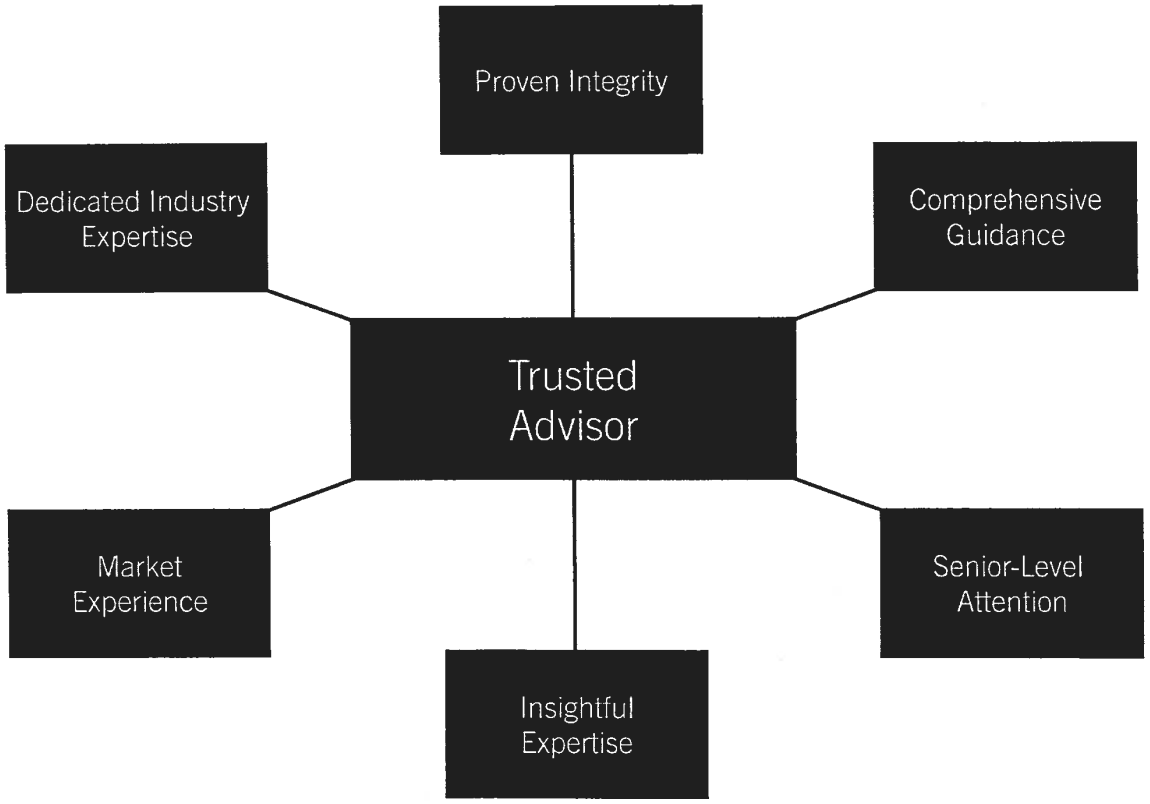
Rank	Advisor	Number of Deals
1	Houlihan Lokey	642
2	JP Morgan	516
3	Bank of America Merrill Lynch	368
4	Morgan Stanley	323
5	UBS	304
6	Goldman Sachs & Co	287
7	Duff and Phelps	267
8	Credit Suisse	220
9	Citi	183
10	Somerley Ltd	181

Source: Thomson Reuters

More Boards and Special Committees rely on Houlihan Lokey than any other advisor

Fairness Opinion Services

Expert Advisors. Expert Opinions.



Fairness Opinion Services

Serving Companies Across a Broad Spectrum of Industries

Fairness Opinion Services

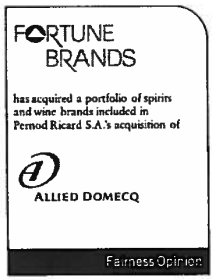
Additional Selected Recent Fairness Opinion Engagements

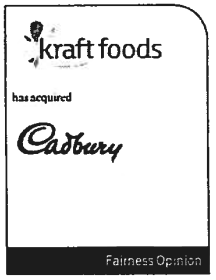
Fairness Opinion Services

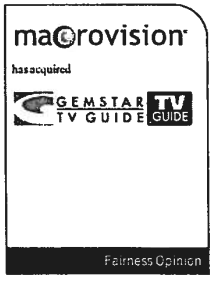
Selected Recent Special Committee Fairness Opinions

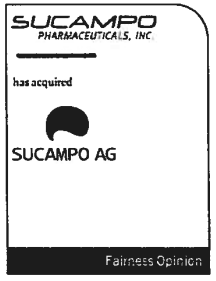
Fairness Opinion Services

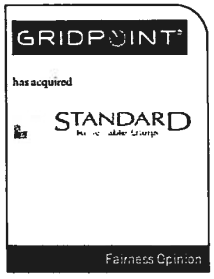
Selected Recent Buyside Fairness Opinion Engagements

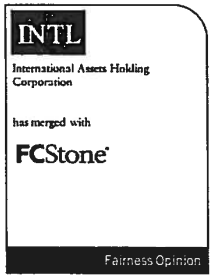


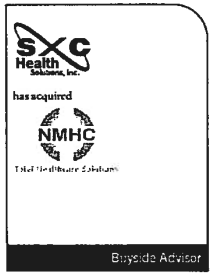


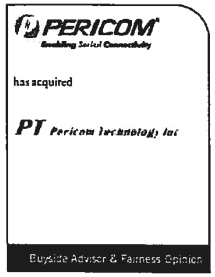


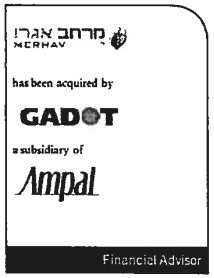












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Fairness Opinion Services

Selected "Second" Fairness Opinion Engagements

Fairness Opinion Services

Selected Related Party Fairness Opinion Engagements

FORUM / TRITON / GLOBAL FLOW TECHNOLOGIES

each a portfolio company of SCF Partners

have combined to form

FORUM

Forum Energy Technologies

Fairness Opinions

CROSSTEX

completed certain transactions including the acquisition of $180 million Series C Senior Subordinated Limited Partnership units from its affiliate, Crosstex Energy, L.P., and the sale of 156,070 shares of its common stock to an affiliated party.

Fairness Opinion

Virbac

Virbac Corporation

has been acquired by

Virbac S.A.

Sellside Advisor & Fairness Opinion

WESTMORELAND COAL COMPANY

$15,000,000
Senior Secured
Convertible Notes

Fairness Opinion

BioVeris

has sold certain intellectual property and related assets to

32 Mott Street Acquisition I and
32 Mott Street Acquisition II

Sellside Advisor & Fairness Opinion

Harbinger Group Inc.

has acquired a majority interest in

Spectrum BRANDS

Due Diligence and Fairness Opinion

MISSISSIPPI BELLE II Riverboat Casino

has been acquired by

A Private Investor

Fairness Opinion

DAI Development Alternatives, Inc.

has acquired
all the outstanding shares
of its common stock not held by

The Development Alternatives, Inc.
Employee Stock Ownership Plan

Financial Advisor & Fairness Opinion

SAIC
From Science to Solutions

has converted its Class A and Class B common shares into Class A preferred shares of the newly formed SAIC, Inc. in a merger transaction

Financial Opinion

V&S Vin & Sprit AB

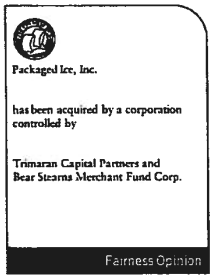
has acquired the remaining shares of

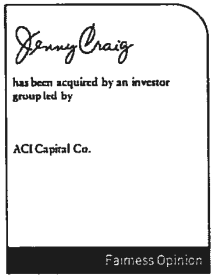
CRUZAN
INTERNATIONAL INC.

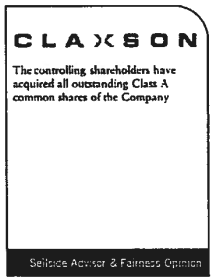
Fairness Opinion

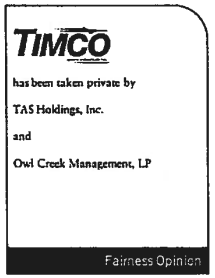
Fairness Opinion Services

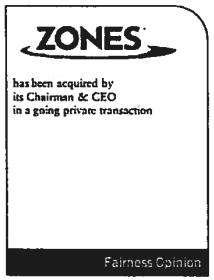
Selected 13e-3 Going Private Fairness Opinion Engagements

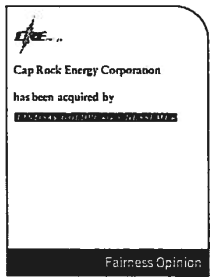












Fairness Opinion Services

Selected Exchange/Restructuring Fairness Opinion Engagements

has completed a debt to equity conversion

Fairness Opinion

Paxson Communications Corporation

has restructured approximately $703.6 million of Series B Convertible Exchangeable Preferred Stock and associated Warrants

Fairness Opinion

has completed a debt and equity recapitalization and merged with GMEC Recapitalization Corporation, a newly-formed company

Fairness Opinion

has agreed to an equity investment involving

Paulson & Co. Inc., Apollo Management VI, L.P. and TPG Capital, L.P.

Fairness Opinion

has completed a stock recapitalization to eliminate its dual class structure and provide all shareholders with voting rights proportionate to their economic interest in the Company

Fairness Opinion

has completed an equity offering and a debt exchange transaction

Fairness Opinions

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Overview of Houlihan Lokey / Healthcare Group

Overview of Houlihan Lokey / Healthcare Group

Leading Healthcare Investment Bank

Capabilities

- #1 advisor in U.S. sellside middle-market (<$1 billion) healthcare transactions over the last three years
- Extensive transaction experience - completed over 125 M&A, fairness opinion and restructuring transactions
- Dedicated M&A professionals exclusively covering the Healthcare Marketplace
- Long-term relationship driven approach toward clients and transactions

Market Leading Healthcare Advisor

No. 1 Healthcare Investment Banking Advisor
U.S. Sellside Transactions Under $1 Billion
2008-2010

Rank	Advisor	Number of Deals
1	Houlihan Lokey	31
2 *	Goldman Sachs & Co	27
2 *	Cain Brothers Co.	27
2 *	JP Morgan	27
5	Lazard	21
6	Piper Jaffray Cos	20
7	Bank of America Merrill Lynch	19
8 *	Jefferies & Co Inc	14
8 *	UBS	14
10	BC Ziegler	11

** denotes tie.*
Source: Thomson Reuters.

2008 M&A Advisory Rankings
All U.S. Healthcare Transactions

Rank	Advisor	Number of Deals
1	Houlihan Lokey	18
2	JP Morgan	17
3 *	UBS	15
3 *	Goldman Sachs & Co	15
5 *	The Braff Group	14
5 *	Morgan Stanley	14
7	Piper Jaffray Cos	13
8	Lazard	12
9 *	Credit Suisse	11
9 *	Merrill Lynch	11

** denotes tie.*
Source: Thomson Reuters.

2007 M&A Advisory Rankings
U.S. Sellside Healthcare Deals Under $750 Million

Rank	Advisor	Number of Deals
1	Houlihan Lokey	12
2	UBS	11
3 *	Goldman Sachs & Co	9
3 *	William Blair & Co	9
5	JP Morgan	8
6	Wachovia Corp	7
7 *	Lazard	6
7 *	Morgan Stanley	6
7 *	Banc of America Securities LLC	6
10 *	Robert W Baird & Co Inc	5
10 *	Cain Brothers Co.	5
10 *	Jefferies & Co Inc	5

** denotes tie.*
Source: Thomson Financial

2006 M&A Advisory Rankings
U.S. Healthcare Deals Under $1 Billion

Rank	Advisor	Number of Deals
1	UBS	18
2	Houlihan Lokey	16
3	JP Morgan	14
4 *	Banc of America Securities LLC	12
4 *	Citigroup	12
6 *	Goldman Sachs & Co	10
6 *	Piper Jaffray Cos	10
8	Merrill Lynch & Co Inc	8
9 *	Duff and Phelps	7
9 *	Jefferies & Co Inc	7

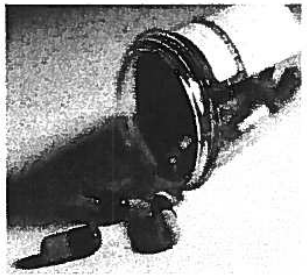
** denotes tie.*
Source: Thomson Financial

Overview of Houlihan Lokey / Healthcare Group

Extensive Experience in All Major Healthcare Sectors

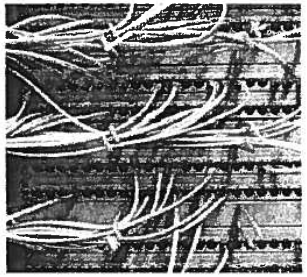
Healthcare Services

- Hospitals
- ASC / Specialty Hospitals
- Long-term Care
- Behavioral Health
- Diagnostic Imaging
- Distribution
- Home Nursing / Hospice
- Institutional Pharmacy
- Laboratories
- Outpatient Facilities
- Physician Services/PPMs/DPMs
- Rehabilitation
- Staffing



Med Tech / Life Sciences

- Medical Technology
  - Med Devices
  - Med Supplies
  - Capital Equipment
  - Diagnostics
- Pharmaceuticals
  - Contract Manufacturers
  - Sterile Production
  - Contract Sales
  - Drug Delivery
  - Generics
  - Specialty Pharma
- Biotechnology
  - Emerging
  - Large Cap



Healthcare Information Technology

- Software/Connectivity
- IT Outsourcing/ASP
- Clearing House
- Consulting and Data Analytics
- Web Portals
- Electronic Health Record
- Decision Support
- Electronic Prescribing
- Billing and Collections
- Coding

Managed Care

- Health Maintenance Organization
- Preferred Provider Organization
- Diversified
- Third Party Administrator
- Outsourced Service Provider

Extensive Hospital Transaction Experience

- Houlihan Lokey is a leader in the hospital industry with selected clients that include:
  - Adventist Health Services
  - Allegheny Health Education and Research
  - Ardent Health Services
  - Arizona Heart Hospital
  - Avera McKennan Hospital
  - Baylor Healthcare System
  - Bossier Medical Center
  - Dayton Heart Hospital
  - Delaware Valley Medical Center
  - East Texas Medical Center
  - Forum Health
  - Fresno Heart Hospital
  - Glenwood Regional Medical Center
  - HCA
  - Health Management Associates
  - HealthSouth
  - Heart Hospital of Lafayette
  - Heart Hospital of South Dakota
  - Henry Mayo Newhall Memorial Hospital
  - Hillcrest Baptist Medical
  - Kansas Heart Hospital
  - LifePoint Hospitals
  - Louisiana Heart Hospital
  - MedCath
  - Oklahoma Heart Hospitals
  - Plymouth Health
  - Porter Memorial Hospital
  - Psychiatric Solutions
  - Rockdale Medical Center
  - Sequoia Hospital District
  - Saint Anthony's
  - Saint Vincent Catholic Medical Centers of New York
  - Selby General Hospital
  - Tenet Healthcare
  - Triad Hospital
  - Triumph HealthCare
  - Universal Health Services
  - Valley Baptist Medical Center
  - Vanguard Health Systems

Not-For-Profit Experience

Houlihan Lokey has advised in a variety of not-for-profit situations including: sellside and buyside transactions, financings, stock valuations and restructurings. Additionally, we have advised state's attorney generals in their review of transactions and conversions. Notable engagements include:

- Serving as the investment banker to Forum Health leading the system's restructuring and sale processes while in Chapter 11
- Served as the financial advisor to the Official Committee of Unsecured Creditors and also served as the transaction broker to the National Benevolent Association for the sale of 11 owned senior care facilities
- Served as the financial advisor to the Official Unsecured Creditor's Committee of Allegheny Health Education and Research Foundation's ("AHERF") Philadelphia operations
  - In addition, Houlihan Lokey helped market and sell AHERF's Pittsburgh operations to The Healthcare Alliance of Western Pennsylvania
- Advised the Attorney General of New Mexico on the acquisition of BlueCross BlueShield of New Mexico by Health Care Service Corporation
- Served as the financial advisor to the Official Committee of Unsecured Creditors of Saint Vincent Catholic Medical Centers of New York
- Advised the Attorney General of California on:
  - The acquisition of Daniel Freeman Hospitals by Tenet Healthcare Corporation and
  - The fair market value of Watsonville Community Hospital
- Advised BlueCross BlueShield of Maine in connection with a planned conversion
- Other selected not-for-profit clients include:
  - Firelands Regional Medical Center
  - Glenwood Regional Medical Center
  - Oklahoma Heart Hospital
  - Rockdale Medical Center

Overview of Houlihan Lokey / Healthcare Group

Select Transaction Experience

Hospitals & Outpatient Surgery:

Long-Term Care Providers:

Overview of Houlihan Lokey / Healthcare Group

Select Transaction Experience (cont.)

Home Care:

and certain subsidiaries
have been acquired by
GENTIVA
Sellside Advisor

has acquired
GIRLING
Buyside Advisor & Private Financing

ACCUMED
a portfolio company of
Parthenon Capital
has been acquired by
a portfolio company of
Arcapita Inc.
Sellside Advisor

AUXI HEALTH
has been acquired by
Sellside Advisor

INTEGRICARE
has been acquired by
Amedisys
Sellside Advisor

VITAS
has been acquired by
ROTO-ROOTER
Sellside Advisor

has been acquired by
GENTIVA
Sellside Advisor

Rehab:

Accelerated
has been recapitalized by
Sellside Advisor

Select Rehabilitation
Select Rehabilitation, Inc.
$34,500,000
Senior Subordinated Notes
Private Financing

HEALTHSOUTH
has confirmed consent solicitations to amend notes

Life Sciences:

genzyme
Genzyme Corporation
has exchanged shares of
Genzyme General
for shares of
Genzyme Biosurgery
and
Genzyme Molecular Oncology
Fairness Opinion

KOS
KOS Pharmaceuticals, Inc.
has committed to purchase up to $8 million of Series F Preferred Stock of
Triad Pharmaceuticals, Inc.
Fairness Opinion

DOV
has successfully completed an exchange offer of $70 million par value of convertible subordinated debentures for convertible preferred stock and cash
Company Advisor

iti
Intranasal Therapeutics, Inc
has secured a commitment of
$39,100,000
Series A Preferred Stock
Private Financing

Specialty / Pharmacy Benefit Management:

has been acquired by
Walgreens Specialty Pharmacy
Sellside Advisor

SXC Health Solutions, Inc.
has acquired
NMHC
Buyside Advisor

HospiScript
has been acquired by
HEALTHEXTRAS
Sellside Advisor

Institutional & Retail Pharmacy:

Kindred
AmerisourceBergen
Kindred Healthcare, Inc
and
AmerisourceBergen Corporation
have merged their respective institutional pharmacy businesses to create
PharMerica
PharMerica Corporation
Financial Opinion

PharMaster, L.P.
has been acquired by
PharMerica
Sellside Advisor

AP
ADVANCED PHARMACY
has completed a $28,000,000 debt and equity financing
Private Financing

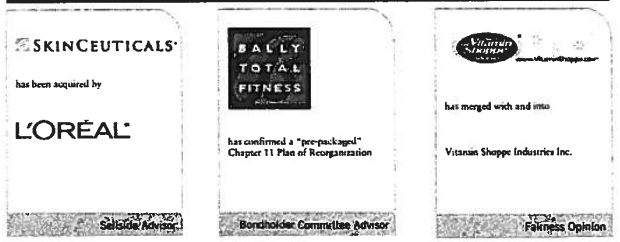
RITE AID
$122,500,000 HAMEDS℠ Series E Mandatory Convertible Preferred Stock
$113,100,000 Series F Cumulative Convertible Pay-in-Kind Preferred Stock
$113,100,000 Series G Cumulative Convertible Pay-in-Kind Preferred Stock
$113,100,062 Series H Cumulative Convertible Pay-in-Kind Preferred Stock
Fairness Opinion

Overview of Houlihan Lokey / Healthcare Group

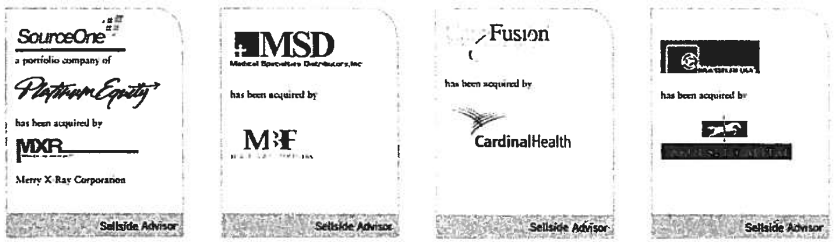
Select Transaction Experience (cont.)

Managed Care:

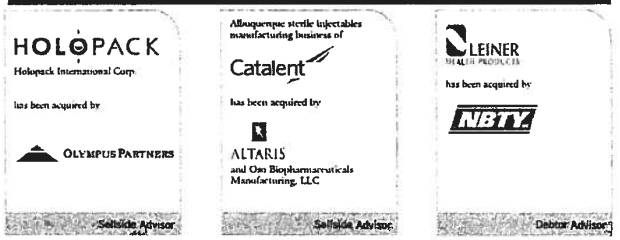
Disease Management / Wellness:



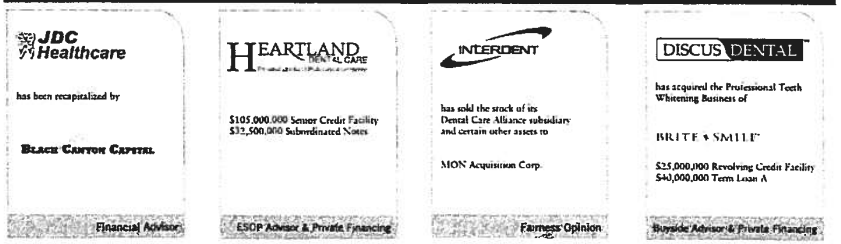
Distribution



Contract Manufacturing:



Dental:



Overview of Houlihan Lokey / Healthcare Group

Select Transaction Experience (cont.)

Med Tech and Devices:

DenMat. has completed a recapitalization transaction including an equity investment from DLJ Merchant Banking — Company Advisor	Celsis has acquired VITRO — Buyside Advisor	STRATAGENE has been acquired by Agilent Technologies — Fairness Opinion	WEST Pharmaceutical Services has sold the assets of the Company's GPI Clinical Services Division to COVANCE — Sellside Advisor	CRYO COR has been acquired by Boston Scientific — Fairness Opinion	has invested $66,000,000 in AVALON LABORATORIES — Company Advisor	DADE BEHRING has confirmed a "prepackaged" Chapter 11 Plan of Reorganization — Company Advisor

HCIT:

ReedGroup has been acquired by Audax Group — Sellside Advisor	Achieve has been acquired by Logibec — Sellside Advisor	Avega Avega Health Systems has been acquired by MedAssets — Sellside Advisor	SDI has acquired VERISPAN — Private Financing/Buyside Advisor	Trover Solutions, Inc. has been acquired by TAILWIND CAPITAL PARTNERS — Sellside Advisor	rims Resource Information Management Systems has been acquired by TRIZETTO — Sellside Advisor	Patriot Technologies has been acquired by HARRIS — Sellside Advisor

Clinical Lab / Diagnostic Screening Services:

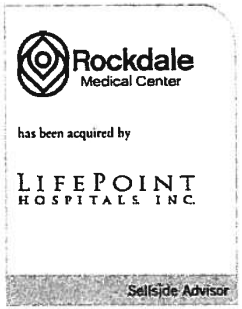
Clinical Laboratories of Hawaii, LLP has been acquired by SONIC HEALTHCARE — Sellside Advisor	Clinical Laboratories of Colorado has been acquired by Quest Diagnostics — Sellside Advisor	Pan Pacific Pathologists, Inc. has been acquired by SONIC HEALTHCARE — Sellside Advisor	LabOne has been recapitalized by — Sellside Advisor	invitrogen has merged with NOVEX — Fairness Opinion	LabOne has acquired OSBORN GROUP, INC. from — Buyside Advisor	WYLE has been acquired in a management-led buyout $30,000,000 Senior Secured Credit Facility $12,400,000 Senior Secured Mortgage Notes $4,000,000 Common Stock — Sellside Advisor & Private Financing

Overview of Houlihan Lokey / Healthcare Group

Select Houlihan Healthcare Transaction Case Studies

Select Houlihan Healthcare Transaction Case Studies

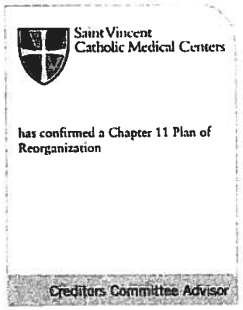
Selected Houlihan Healthcare Case Study – Rockdale Medical Center, Inc.



- ***Client Profile*** – Rockdale Medical Center ("RMC") is a JCAHO accredited 138 licensed bed, not-for-profit hospital that provides acute care, diagnostic services, emergency services and outpatient services throughout the local community. RMC is located in Conyers, Georgia, approximately 25 miles east of Atlanta and is the only hospital in Rockdale County. In 2002, RMC began a significant expansion and renovation project that caused the facility to borrow in excess of $90.0 million. As a result of this increased debt level, RMC began to experience significant difficulties in meeting its debt service, and ultimately went into covenant default. In accordance with the bond documents, RMC engaged several consulting firms to assist with performance improvement plans.
- ***Houlihan Lokey's Role*** – After being engaged as RMC's exclusive financial advisor, Houlihan Lokey conducted a comprehensive strategic review in conjunction with management and the board. We reviewed the following alternatives with the board: a physician syndication, a guarantee by the lead lender, a guarantee by the county, a joint venture and a sale of the hospital. After multiple avenues had been exhausted, it became apparent that the best option for the ongoing viability of the hospital and the provision of comprehensive healthcare services in Rockdale County was to sell the facility to a strategic party. As such, Houlihan Lokey conducted a comprehensive marketing process and negotiated the sale of RMC.
- ***Transaction Snapshot*** – Houlihan Lokey structured a sale of the assets to LifePoint Hospitals. Houlihan Lokey's highly competitive process resulted in LifePoint Hospitals emerging as the lead bidder with a premium purchase price, a commitment to fund a minimum of $30.0 million in future capital expenditures and favorable transaction terms.

Select Houlihan Healthcare Transaction Case Studies

Selected Houlihan Healthcare Case Study – Saint Vincent Catholic Medical Centers of New York



- ***Client Profile*** – Saint Vincent Catholic Medical Centers ("SVCMC") is a comprehensive healthcare system which as of its July 5, 2005 bankruptcy filing employed over 2,500 physicians and in the calendar year prior to filing recorded more than 600,000 outpatient visits, 640,000 home care visits and 92,000 inpatient discharges. At filing, SVCMC operated seven hospitals located in four boroughs of New York City and in Westchester County. SVCMC also operated three nursing homes, a hospice, a home health business, a health maintenance organization and two captive insurance companies. SVCMC's flagship hospital was Saint Vincent Manhattan a 758-bed hospital located in Greenwich Village.
- ***Houlihan Lokey's Role*** – Houlihan Lokey served as financial advisor to the Official Committee of Unsecured Creditors in connection with SVCMC's Chapter 11 filing in the Southern District of New York.
- ***Transaction Snapshot*** – At the outset of the case the debtors suffered from a lack of liquidity and were struggling to close / monetize non-core assets. The Houlihan Lokey team immersed ourselves in many key initiatives to provide the direction and coordination that previously had been lacking and created critical alliances with the DOH, DASNY, HUD and the U.S. Trustee to ensure that creditors' interests were addressed and that SVCMC's operations were stabilized. Among the many issues in which Houlihan Lokey played a significant role working on behalf of creditors was obtaining permanent DIP financing, selection of interim senior management (CEO and CRO), closing non-core asset sales, assessing and implementing various real estate monetization options, selection of a real estate consultant given SVCMC's extensive real estate assets, testing and finalizing a long-term business plan and developing and negotiating alternative plan structures and methods of creditor repayment. Throughout the case Houlihan Lokey worked constructively with all constituents including the PBGC, the Tort Claimants' Committee, the Ad Hoc Committee of Secondary Claims Traders and SVCMC's management and advisors which helped facilitate a successful plan of reorganization which provides unsecured creditors with a 100% recovery.

Houlihan Execution and Support Team Biographies

Ben A. Buettell

Mr. Buettell is a Managing Director in Houlihan Lokey's Chicago office and a senior member of the firm's Financial Advisory Services business. He serves as co-head of the firm's Fairness Opinion practice and is the head of the firm's Solvency Opinion practice.

Mr. Buettell has more than two decades of experience providing financial advisory services to public and private clients in connection with mergers, acquisitions, leveraged buyouts, spinoffs, recapitalizations, going-private transactions and strategic alternative assessments. He also renders fairness, solvency and transaction-related opinions to companies, boards of directors, special committees, financial institutions and independent fiduciaries.

Before joining Houlihan Lokey, Mr. Buettell worked for a Chicago-based financial institution as a commercial loan officer, serving privately held middle-market companies.

Mr. Buettell served on the board of directors of Euclid Beverage from August 2006 to August 2009. He also serves on the board of directors of the Boys and Girls Clubs of Chicago.

Mr. Buettell earned his B.A. in economics from Northwestern University and a master of management degree in finance and management policy from Northwestern University's Kellogg School of Management. He is registered with FINRA as a General Securities Principal (Series 7, 24 and 63) and a Limited Representative – Investment Banking (Series 79).

Gary D. Brewster

Mr. Brewster is a Managing Director in Houlihan Lokey's New York office, where he is a member of the Financial Advisory Services business and the Healthcare Group. He has provided financial advisory services for mergers, acquisitions, joint ventures and alliances, strategic investments, and financings. He has also provided valuation opinions for private disputes and for regulatory agencies. He has served a number of healthcare industry sectors, including pharmaceutical, medical device, biotechnology, healthcare services, and information technology.

Before joining Houlihan Lokey, Mr. Brewster worked for Standard & Poor's, PricewaterhouseCoopers and IBM.

Mr. Brewster has spoken at numerous industry and technical conferences. He has been a long-time supporter of the educational programs of Inner City Scholarship Fund and Carnegie Hall.

Mr. Brewster received a B.S. in industrial engineering from Stanford University and earned his M.B.A. from the Wharton School. He is registered with FINRA as a General Securities Representative (Series 7 and 63) and a Limited Representative – Investment Banking (Series 79).

Mark Francis

Mr. Francis is a Managing Director in Houlihan Lokey's Dallas office, where he is Co-Head of the Healthcare Group. He has nearly two decades of experience in mergers and acquisitions and financial operations in the healthcare industry, and he has managed a wide variety of projects, from acquisitions, divestitures, financings and financial restructurings to joint ventures and strategic-alliance formation.

Before joining Houlihan Lokey, Mr. Francis directed a national team of acquisition professionals as vice president of M&A for the home health division of HCA. He speaks frequently on mergers and acquisitions and finance in the healthcare industry.

Mr. Francis earned a B.B.A. in finance from Baylor University. He is a Certified Public Accountant and is registered with FINRA as a General Securities Principal (Series 7, 24 and 63) and a Limited Representative – Investment Banking (Series 79).

Sam W. Clark

Mr. Clark is a Managing Director in Houlihan Lokey's Dallas office, where he heads the firm's Financial Advisory Services effort in the Southwest and is the global leader of the Tax and Financial

Reporting and Transaction Advisory Services practices. He has over 25 years of experience advising clients on mergers and acquisitions, valuations, financings, and assessing strategic alternatives in such industries as healthcare, technology, manufacturing, real estate and energy.

Before joining Houlihan Lokey, Mr. Clark was a managing director and the founder of Standard & Poor's Southwest Valuation practice, formerly the PricewaterhouseCoopers Southwest Regional Valuation practice. Before that, he was the managing director of PricewaterhouseCoopers Southwest Regional Valuation and Corporate Finance practice.

Mr. Clark earned a B.B.A. in finance from Texas A&M University and an M.B.A. in finance from the University of North Texas. He completed an executive development program at Northwestern University and valuation coursework at Harvard University. He is a Certified Public Accountant accredited in business valuation, a senior member of the American Society of Appraisers, a licensed real estate broker and a state-certified general real estate appraiser. He is registered with FINRA as a General Securities Representative (Series 7 and 63) and a Limited Representative – Investment Banking (Series 79).

Michael DeLuke

Mr. DeLuke is a Director in Houlihan Lokey's Dallas office. He has more than a decade of professional services and valuation experience in the healthcare, financial services, manufacturing and energy industries.

Before joining Houlihan Lokey, Mr. DeLuke was a manager in PricewaterhouseCoopers' Standard & Poor's corporate value consulting practice, where his valuation assignments addressed acquisitions, divestitures, fairness opinions, corporate planning, purchase price allocations, and financial advisory. Earlier, he worked for several years at another accounting firm, performing business valuations and providing tax and audit services.

Mr. DeLuke has a B.B.A. in accounting from Baylor University, a master's degree in taxation from Baylor University, and an M.B.A. in finance from the University of Texas. He is a member of the American Institute of Certified Public Accountants and the Texas Society of Certified Public Accountants. He is also a member of the Financial Accounting Standard Board's Valuation Resource Group, which identifies and resolves fair-value measurement issues. He is registered with FINRA as a General Securities Representative (Series 7 and 63) and a Limited Representative – Investment Banking (Series 79).

RESPONSE TO RFP

FOR

FAIRNESS EVALUATION FOR CONVERSION OF GREATER WATERBURY HEALTH NETWORK, INC.

SUBMITTED TO:
GREATER WATERBURY HEALTH NETWORK, INC.
ATTENTION: MS. DARLENE STROMSTAD, FACHE
PRESIDENT/CEO
64 ROBBINS STREET
WATERBURY, CONNECTICUT 06708

Principle Valuation, LLC

PEOPLE AND VALUES YOU CAN TRUST

October 13, 2011

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Attention: Ms. Darlene Stromstad, FACHE
President/CEO

Re: Fairness Evaluation for Conversion of Greater Waterbury Health Network, Inc.

This letter serves as our proposal to provide the Board of Directors of Greater Waterbury Heath Network, Inc ("Board", or "GWHN") a Fairness Evaluation in conjunction with its announced three-way joint venture (the "Transaction") with St. Mary's Health System, Inc. and LHP Hospital Group, Inc.

PURPOSE AND BACKGROUND

We understand that the purpose of our analysis will be to provide the Board a fairness evaluation of the Transaction in order for the Board to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute t19a-486 et seq. ("Conversion Statute").

SCOPE

In determining whether the consideration is fair from a financial point of view, we will specifically address the following valuation issues and considerations:

- Assess the "Fair Market Value" of the assets to be transferred by GWHN
- Assess the intangible value to the Greater Waterbury community of maintaining the of GWHN
- Assess the value from a financial point of view of the commitment to build a replacement facility
- Assess from a financial point of view the value of the management agreement that the joint venture will enter into with an LHP affiliate to manage the hospital's operations

In conducting these assessments the following considerations will be made:

- Review the terms associated with the Transaction

- Conduct a site visit to the Hospital to accurately describe and assess the condition of the assets to be transferred
- Review the historical and earning potential of the operating assets that GWHN intends to transfer
- Review and analyze the terms associated with the Management Agreement to be entered into with an affiliate of LHP
- Review the plans, budgets, and financial projections associated with the replacement facility
- Consider the overall market potential of the Waterbury Hospital and the combined joint venture separately and as combined
- Review and analyze other pertinent and necessary information necessary to arrive at our final opinions
- Review and extrapolate transactions that involved for-profit versus non-for-profit organizations and academic hospital systems versus community hospital systems

Fair Market Value for the purposes of this analysis will be defined as follows:

> The most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

PRINCIPLE VALUATION FIRM OVERVIEW, RELEVANT EXPERIENCE, AND TEAM MEMBERS

In 2007, Timothy Baker and David Felsenthal combined their 75 years of healthcare appraisal experience to form Principle Valuation, a firm dedicated to service the specialized needs of the healthcare community. In 2009, Patrick Simers joined as a Principal in the firm and added to the strength of the overall hospital valuation core with more than 25 years in the appraisal of Healthcare properties. All of the Principals of Principle Valuation,("PV" and "Principle"), have served as Presidents and Vice Presidents of many of the major healthcare valuation and healthcare consulting providers including Huron Consulting, American Appraisal, CBIZ, and Valuation Counselors, a valuation firm that Mr. Felsenthal had previously founded which was once recognized as the premier healthcare valuation firm in the industry. From inception our staff has continued to expand and we now have more than seventeen professional employees dedicated to the valuation of healthcare related entities.

Our business is generally segmented into three primary sectors; Hospital and Healthcare Enterprise Related Services, Healthcare Advisory Services; and Senior Housing Related Services.

In the Hospital and Healthcare Related services group, the primary emphasis is to prepare valuations to meet the regulatory guidelines associated with hospital transactions including Stark compliance, State Regulatory Requirements and Purchase Accounting. Valuations conducted in this sector generally include the valuation of hospitals and hospital systems, medical practices, joint ventures valuations, service agreements and other types of healthcare business arrangements. Another major focus of this group is the valuation of tangible and intangible assets associated with purchase accounting for Acute and Specialty Hospitals. Professionals in this group have real estate, medical equipment, and business enterprise expertise.

The Healthcare Advisory Services group is primarily responsible for the preparation of cost segregation studies, facility live analysis, and asset inventory and reconciliation reports. This group's personnel consists of staff members with engineering and tax expertise that assist our clients in reducing their overall tax liability and developing accurate property records that help our clients increase their overall bond ratings. Our Senior Housing Group focuses on the service needs of the senior housing industry. This group prepares market studies and valuations of nursing homes and assisted living residences. Their work is generally presented for financing and utilized to obtain conventional financing and through the HUD 232 program. Professionals in this group include real estate professionals who have detailed knowledge of the regulatory rules and reimbursement policies that dictate the seniors housing industry.

Particularly relevant engagements include fairness reviews and appraisals presented to comply with the Attorney General requirements in Georgia, Mississippi, Louisiana, Florida, Pennsylvania, and New Jersey. Direct hospital transfer assessments included Banks-Jackson-Commerce Hospital in Georgia; Baptist Memorial Hospital – North Mississippi in Mississippi; Ville Platte Medical Center and West Carroll Memorial Hospital in Louisiana; South Shore Hospital in Miami, Florida; and UPMC in Pittsburgh, Pennsylvania. We also recently assessed a hospital management agreement for Meadowlands Hospital Medical Center in New Jersey.

The primary parties that will be active in this engagement include Tim Baker, Patrick Simers, John Leary, and Mary Jo Duffy. As demonstrated by their Qualifications, each member of the team has more than 25 years in the valuation of healthcare enterprises and includes individuals with General Appraiser State Certifications, CFA's, and CPA's. These qualifications are included in the Addenda of this proposal.

DUE DILIGENCE DATA REQUIREMENTS

The following information will be initially and primarily required in order to complete the assignment:

- A Central Contact that is familiar with the overall operations and contemplated transaction. This person will serve as our primary contact and should be able to discuss the financial, and market environment for the assets under consideration. Further this person should have the ability to coordinate site visits with our staff with the Hospital
- Audited Financial Statements of GWHN and its primary operating units for the past three years along with the current year-to-date operations and budgets.
- Forecasted operations for the next three-five year period for Waterbury Hospital operations
- A current Balance Sheet of the Organization and an explanation of which assets are anticipated to transfer
- A copy of the current fixed asset ledger of the Hospital and its associated entities in an excel format
- A listing of all real estate property anticipated to transfer with the transaction; including the address of the property, a brief description of the improvements including its size and use, its associated tax parcel number, and the size of the underlying land parcel
- A copy of any Board Minutes that discussed the contemplated Transaction
- A copy of any reports or presentations that Cain Brother's prepared in making its overall recommendations to the Board
- A copy of the Medicare Cost Reports for the prior two fiscal periods
- A non-redacted version of the CON Application that St. Mary's and LHP provided to the State
- The Current Plans, Budgets, and Forecasted Financials for the Replacement Facility
- A copy of the Management Agreement anticipated between GWHN and LHP
- A Contact at LHP that we can discuss their overall business operations, history, capital resources, financials, etc.
- The Management and Organizational Structure associated with the Joint Venture
- Any Demographic, Market Research, or Competitive Surveys that were conducted to support the overall merger
- A brief write-up of the subject's current ownership and operational history
- Any other data that you feel is necessary that enhances our understanding of the Transaction

PROCESS TIMELINE, LOGISTICS, AND COORDINATION

We would anticipate the following general time line which would lead to an overall engagement completion by November 30, 2011.

- First Week (Oct. 21) — Award of contract and receipt of data requested
- Second Week (Oct. 28) — In-house review of data received and prepare plan for on-site visit to be conducted in the third week
- Third Week (Nov. 4) — Conduct on site visit October 31-November 3 This will primarily consist of a time spent verifying asset lists and getting descriptive data on improvements
- Fourth Week (Nov. 11) — In-Office Pricing, Research, and Development of Preliminary Estimates
- Fifth Week (Nov. 17) — Presentation of Preliminary Findings and Draft Report Development
- Sixth Week (Nov. 25) — Client Review of Draft Report (Thanksgiving Week)
- Seventh Week (Nov. 30) — Adjustments and Development of Final Report

We believe that this time line is reasonable based upon the overall effort and personnel that would be involved in this analysis. Should a tighter time frame be needed, we may be able to accommodate. All time estimates assume that all data requests are promptly received on an ongoing basis throughout the engagement process. We would immediately notify you should any delays in the receipt of information or other items beyond our control would push back these delivery timelines.

CONFIRMATION OF ABSENCE OF ANY CONFLICTS OF INTEREST

Neither Principle Valuation nor its staff members have any known conflict of interest with the parties to this Transaction or to the Transaction itself.

COMPENSATION STRUCTURE

Our fee for this engagement will be [redacted] inclusive of all expenses. We ask that a retainer of [redacted] be issued upon acceptance of this letter. We will subsequently bill [redacted] upon presentation of our initial findings and draft report. We anticipate all payments to be current prior to issuing our final report. Our final invoice, [redacted] will accompany our final report; or if no final report is desired, upon your indication that no final report is required. Our fee is in no way contingent upon the outcome of our conclusions. This fee is based on our estimate of professional services to be furnished, according to our understanding of your requirements; should the scope of these requirements change, Principle Valuation and Greater Waterbury Health Network, Inc. will mutually revise the fee to reflect those changes in services.

Fees include professional time for planning and executing the work through, and including, our final report. Should you require additional consultation based on your reviews of our work or those of your external auditors or your tax or other advisors, or any public presentation, testimony and appearance in front of any tribunal, agency or other body, subsequent payment will be required and we will bill for those services at our prevailing hourly rate for the personnel involved.

We reserve the right to withhold delivery of our preliminary conclusions or final report(s) if, when either of these is ready for delivery, any previously issued invoice remains unpaid. We reserve the right to issue interim or final invoices, as appropriate, should you delay the project and/or in the event that our preliminary or draft report has been in your possession for more than 30 days.

You have the right to terminate this assignment at any time, in which case there will be no further obligation on the part of either party to continue. In such event, you will be obligated to pay only for the actual time and charges accumulated through the date of cessation.

GWHN agrees to indemnify and hold harmless Principle Valuation, its employees, and representatives, collectively ("Principle") from and against any and all losses, claims, damages, or liabilities, joint or several, including all reasonable out-of-pocket expenses, fees, and disbursements of counsel incurred by Principle in defending any claim, action, or proceeding whether or not resulting in a liability to Principle to which they may become subject, caused by, arising out of or in connection with this engagement, including but not limited to, losses, claims, damages or liabilities caused by or arising out of any untrue statements of material fact contained in the information provided to Principle by GWHN or its advisors in connection with our engagement, or any omission to state any therein any material fact required or necessary to make the information not misleading in light of circumstances under which given, or any violation of the federal securities laws or the securities laws of any state, or otherwise arising out of our engagement hereunder except in respect to any matter as to which Principle shall have been adjudicated to have acted with gross negligence or willful malfeasance.

ACKNOWLEDGEMENT

We appreciate this opportunity to provide our recommendations for valuation-consulting services. We are uniquely qualified to perform this assignment, by virtue of our independence, experience, reputation, and expertise. We are committed to completing the work in an efficient and timely manner.

Due to the complexity of the assignment; if any of the terms, as highlighted, need to be discussed or refined please do not hesitate to call us as we would appreciate the opportunity to work with you on this important assignment.
But, if the content of this document correctly reflects your understanding of our agreement, please sign below and return the executed document and return the enclosed copy. This agreement shall remain open and valid for signature for 90 days from the issue date; however, any significant delay in executing this agreement could adversely impact our ability to meet the delivery commitments described herein. Please note we will be unable to start this engagement until we are in receipt of this signed acknowledgment. To avoid any delays in delivery, please

fax the signed acknowledgment to (312) 422-1515. Thereafter, please forward the original to us.

If you have any questions or comments, please call me at (770) 924-8811.

Respectfully submitted,

PRINCIPLE VALUATION, LLC

Patrick J. Simers
PJS/ms

CLIENT: GREATER WATERBURY HEALTH NETWORK, INC.

SIGNATURE(S): _____

NAME (PRINT OR TYPE): _____

TITLE: _____

DATE: _____

PHONE: _____

EXHIBITS

TIMOTHY H. BAKER
PRESIDENT

EXPERIENCE

Mr. Baker has been in the appraisal industry since 1981 with a concentration on healthcare and senior living properties. His valuation experience includes valuing the business enterprise, real estate, and personal property. Valuations have been performed on a national and international basis. Consulting engagements include market and financial feasibility studies.

Mr. Baker has experience in the valuation of numerous healthcare facilities including acute care, behavioral health, and rehabilitation hospitals. Senior living properties include nursing homes, assisted living facilities, and retirement centers. Other related operations include research facilities, healthcare leasing companies, physician practices, and medical office buildings. Mr. Baker has also provided consultations on market assessment, demand analysis, reimbursement issues, development of fixed asset records, and provided analysis of strategic opportunities. Valuation reports prepared by Mr. Baker have been used for several purposes including public offerings, litigation support, HUD 232 and 242 mortgage insurance programs, acquisition/divestitures, property tax purposes, state reimbursement, estate planning, and for internal management decision making.

PROFESSIONAL HISTORY

- 2007 to present – President, Principle Valuation, LLC.
- 2001 to 2007 - Senior Vice President, Wellspring Valuation, Ltd.
- 1997 to 2001 - Vice President, Marshall & Stevens National Healthcare Practice.
- 1992 to 1997 - Senior Manager, Capital Valuation Group, specializing in the valuation of the business and real estate of senior living and healthcare related facilities.
- 1981 to 1992 – Manager, Valuation Counselors where he was responsible for performing a multitude of appraisal and consulting services for clients specializing in business enterprise, real estate, and machinery and equipment.

PROFESSIONAL AFFILIATIONS

- Advisory Committee Member American Senior Housing Association
- Healthcare Financial Management Association
- American Health Lawyers Association
- Associate Member Appraisal Institute

EDUCATION LICENSES, AND DESIGNATIONS

- 1980 graduate of Bucknell University with a Bachelor of Science in Business Administration
- Certified General Real Estate Appraiser Maryland and New Jersey

TESTIMONY

- Testified as expert witness in California, Colorado, Connecticut, New Hampshire, New Jersey and Pennsylvania

PATRICK J. SIMERS
EXECUTIVE VICE PRESIDENT

EXPERIENCE

Mr. Simers has extensive experience in serving the valuation needs of the health-care industry. He has valued all tangible and intangible assets associated with health-care enterprises, including the capital stock of majority and minority share holdings; medical specialty and physician joint ventures; fee simple, leased fee, and leasehold interests in real estate for hospital systems, stand-alone hospital campuses, and medical office buildings; major and minor movable equipment; certificates of need; contractual agreements; and preferred provider arrangements.

Specific healthcare enterprises appraised include acute care hospital facilities, LTACH hospitals, psychiatric hospitals, rehab hospital facilities, single physician practices, multi-specialty practices, cath labs, diagnostic centers, cardiac care practices, home health agencies, nursing homes, assisted living facilities, and medical office buildings.

Mr. Simers has performed fair market value studies for purchase, sale, or financing; merger and acquisition consulting; negotiation of purchase price; fairness opinions; purchase price allocations; financial reporting; SEC reporting; Medicare regulatory requirements; Safe Harbor requirements; and 501(c)(3) private placement offerings.

PROFESSIONAL HISTORY

Mr. Simers began his appraisal career with Valuation Counselors in 1982 and held various consulting, business development, and management roles, including four years as president of Valuation Counselors, leading up to its merger with CBIZ Inc. Most recently, Mr. Simers has served as the National Director for Healthcare services for American Appraisal Associates where he spear-headed the development of healthcare services for this international appraisal firm.

Patrick J. Simers is Executive Vice President for Principle Valuation. He is responsible for the development and overall business plan for Principle's consulting and appraisal services to for-profit, nonprofit, and public health-care providers. Mr. Simers is located in Principle Valuation's Atlanta office.

PROFESSIONAL AFFILIATIONS

- American Health Lawyers Association
- Healthcare Financial Management Association

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Northern Illinois University with a Bachelor of Science in Finance and Economics
- Graduate of Moraine Valley College with a Associate in Arts in Business Administration
- Certified General Real Estate Appraiser in Georgia

JOHN L. LEARY, CFA

EXPERIENCE

Mr. Leary's hospital transaction experience consists of valuations for hospital acquisition and financing transactions in excess of $1 billion, SFAS 144 impairment studies for acute care hospitals, valuations for relative contributions of hospital operations to newly organized joint ventures, and valuations of certificate of need for new hospital construction.

His ambulatory surgery and diagnostic imaging center experience consists of valuation of surgery centers for hospital physician syndications, initial capitalization of joint venture between major metropolitan medical center and physician owned outpatient surgery center, and recapitalization of a multi-modality diagnostic imaging center owned by a partnership consisting of two medical centers and a radiology group.

Mr. Leary also has managed care experience that consists of an equity valuation of Medicaid Provider Service Network serving 50,000 Medicaid members, a SFAS 141 valuation of tangible and intangible assets for a managed care organization with a market capitalization of approximately $1.3 billion, and a purchase price allocation specialty pharmacy and pharmacy benefit management company totaling $1.5 billion.

Mr. Leary has also performed valuations of dialysis, home health, durable medical equipment, respiratory and infusion therapy operations, and physician practices

PROFESSIONAL HISTORY

- 1989 to 2011 - CBIZ Valuation Group, LLC — Atlanta, GA
  Southeastern Director of Financial Valuation Services
- 1987 – 1989 - Carnegie Securities Corporation — Atlanta, GA
  Vice President
- 1980 – 1987 - Storer Cable Communications — Atlanta, GA
  Regional Controller

EDUCATION AND ACCREDITATIONS

- 1978 – 1980 - Georgia State University — Atlanta, GA
  Masters of Business Administration with a concentration in finance
- 1974 – 1978 - Emory University — Atlanta, GA
  Bachelor of Arts with majors in Economics and Political Science
- Chartered Financial Analyst and Certified Public Accountant (inactive license)

MARY JO DUFFY

EXPERIENCE

Ms. Duffy brings 25 years of accounting, auditing, business valuation, business consulting and financial management to her clients. She has testified as an expert witness in deposition and trial, and advised clients on strategy, transactions and general business issues in addition to valuation issues

Ms. Duffy began her career with KPMG as an accountant and auditor. As CEO of Valuation Counselors, a national valuation firm, she provided valuation services to entities as diverse as boat manufacturers, grocery chains, technology ventures and healthcare providers. She served as a partner in a national CPA firm, responsible for appraisal and valuation services nationwide and was a member of the firm's Management Council.

As National Director of Financial Services to the healthcare industry for Coopers & Lybrand L.L.P., a predecessor firm of PricewaterhouseCoopers, Ms. Duffy was responsible for litigation, valuation, merger & acquisition, reorganization and other services to healthcare entities and assisted healthcare clients with matters involving providers, payers and related organizations. She later joined Ernst & Young's Healthcare Consulting practice specializing in physician networks, operations improvement, M&A strategy and post-merger integration. Her expertise in the healthcare arena includes advising providers on strategic options, negotiating transactions and assisting a Debtor in Possession in disposing of the assets, preparing a physician organization for doubling in size and an IPO, and developing integrated networks in academic medical centers and community delivery systems. She has also been the CFO of multi-specialty, multi-site healthcare provider.

PROFESSIONAL HISTORY

- Director, Acuitas, Inc.
- National Director of Financial Services, Coopers & Lybrand
- CEO, Valuation Counselors
- Consultant, Ernst & Young Healthcare Consulting
- Certified Public Accountant and Auditor, KPMG.

PROFESSIONAL AFFILIATIONS

- Leadership Team Member Healthcare Task Force of GSCPAS
- Serves as Board Member for: Turning Point Women's Healthcare, The Childhood Autism Foundation and Emory Austin Resource Center
- Member, Illinois CPA Society
- Officer, Georgia Society of CPAS – Atlanta Chapter

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Georgetown University School of Business
- Certified Public Accountant

HONORABLE DESIGNATIONS

- Honored by Atlanta Magazine as one of Atlanta's outstanding business women.

HEALTHCARE SYSTEMS AND HOSPITALS
OUR PROFESSIONALS HAVE SERVICED SINCE 2000

HEALTHCARE SYSTEMS:	CITY	ST
Advocate Health Care	Oak Brook	IL
Ascension Health	St. Louis	MO
Aurora Health Care	Milwaukee	WI
Banner Health Systems	Phoenix	AZ
Baptist Health South Florida	Coral Gables	FL
Baylor Health Care System	Dallas	TX
Benefis Health System	Great Falls	MT
Capella Healthcare	Franklin	TN
Catholic Health East	Newtown Square	PA
Centura Health	Englewood	CO
CHRISTUS Health	Irving	TX
Community Health Systems, Inc.	Brentwood	TN
Community Memorial Health System	Ventura	CA
Daughters of Charity Health System	Los Altos Hills	CA
Elmhurst Memorial Healthcare	Elmhurst	IL
Envision Corp.	Scottsdale	AZ
Essent Healthcare Inc.	Nashville	TN
Gulf States Health Services	Baton Rouge	LA
Health Care REIT, Inc.	Toledo	OH
Health East	Minneapolis	MN
Health Management Associates	Naples	FL
Holistic Health Care, Inc.	Birmingham	AL
Hospital Sisters Health System	Springfield	IL
Ingalls Health System	Harvey	IL
Jewish Hospital & St. Mary's Healthcare	Louisville	KY
Landmark Hospitals	Cape Girardeau	MO
LifeCare Management Service	Plano	TX
LifePoint Hospitals, Inc.	Brentwood	TN
Memorial Healthcare System	Hollywood	FL
NorthShore University Health System	Evanston	IL
Presbyterian Healthcare Services	Albuquerque	NM
Provena Health	Chicago	IL
Rapid City Regional Hospital	Rapid City	SD
Renaissance Healthcare Systems	Houston	TX
Resurrection Health Care	Chicago	IL
Saint Barnabas Health System	Livingston	NJ

HEALTHCARE SYSTEMS:	CITY	ST
Saint Thomas Health Services	Nashville	TN
Sarasota Memorial Healthcare System	Sarasota	FL
Seton Family of Hospitals	Austin	TX
Sisters of St. Francis Health Services	Mishawaka	IN
Specialty Hospitals of America, LLC	Portsmouth	NH
SSM Regional Health Services/St Mary's Health Center	Jefferson City	MO
St. Anthony Memorial Health Centers	Michigan City	IN
St. Francis Health System	Pittsburgh	PA
St. Vincent's Health System	Birmingham	AL
Summa Health Systems	Akron	OH
Trinity Health	Novi	MI
Universal Health Services	King of Prussia	PA
University Hospital Health System - Cleveland	Cleveland	OH
University Hospital Health System - San Antonio	San Antonio	TX
Vanguard Health Systems	Nashville	TN
Vibra Healthcare	Mechanicsburg	PA

HOSPITALS:	CITY	ST
Carraway Burdick West Medical Center	Haleyville	AL
Carraway Northwest Medical Center	Winfield	AL
Crestwood Medical Center	Huntsville	AL
Hartselle Medical Center	Hartselle	AL
Parkway Medical Center	Decatur	AL
Russellville Hospital	Russellville	AL
Southern Cancer Center	Mobile	AL
Harris Hospital	Newport	AR
Helena Regional Medical Center	Helena	AR
National Park Medical Center	Hot Springs	AR
North Metro Medical Center	Jacksonville	AR
Siloam Springs Memorial Hospital	Siloam Springs	AR
St. Mary's Regional Medical Center	Russellville	AR
Holy Cross Hospital	Nogales	AZ
Plaza del Rio Campus	Sun City	AZ
St. Joseph Hospital	Tucson	AZ
St. Mary's Hospital	Tucson	AZ
Sun Health Del E. Webb Campus	Sun City West	AZ
Tuscan Medical Center	Tucson	AZ
William O. Boswell Hospital	Sun City	AZ
Cedars Sinai Medical Center	Los Angeles	CA

HOSPITALS:	CITY	ST
Community Hospital of the Monterey Peninsula	Monterey	CA
Downey Regional Medical Center	Downey	CA
Hemet Valley Medical Center	Hemet	CA
Hollywood Presbyterian Medical Center	Los Angeles	CA
Kentfield Rehabilitation & Specialty Hospital	Kentfield	CA
Lancaster General Hospital	Lancaster	CA
Menifee Valley Medical Center	Sun City	CA
Norris Comprehensive Cancer Center & Hospital	Los Angeles	CA
Parkview Community Hospital	Riverside	CA
Physicians' Hospital of Rancho California	Murrieta	CA
Robert H. Ballard Rehabilitation Hospital	San Bernardino	CA
San Joaquin Valley Rehabilitation Hospital	Fresno	CA
USC University Hospital	Los Angeles	CA
Ventura Hospital	Ventura	CA
Lutheran Campus ASC LLC	Wheat Ridge	CO
OrthoColorado Hospital	Lakewood	CO
Penrose Hospital	Colorado Springs	CO
St. Anthony North Hospital	Westminster	CO
St. Mary-Corwin Medical Center	Pueblo	CO
St. Thomas More Hospital	Canon City	CO
Capital Hills Hospital	Sharon	CT
Greenwich Hospital	Greenwich	CT
Sharon Hospital	Sharon	CT
Greater Southeast Community Hospital	Washington	DC
Providence Hospital	Washington	DC
Specialty Hospital of Washington-Hadley	Washington	DC
Boca Raton Community Hospital	Miami	FL
Baptist Hospitals of Miami	Miami	FL
Bonita Community Health Center	Boca Raton	FL
East Point Hospital	Bonita Springs	FL
Fishermen's Hospital	Marathon	FL
Health Central Hospital	Ocoee	FL
HealthSouth Ridgelake Hospital	Sarasota	FL
Holy Cross Hospital	Marathon	FL
Homestead Hospital	Fort Lauderdale	FL
Jacksonville Medical Center	Homestead	FL
Mercy Hospital	Miami	FL
Memorial Hospital Pembroke	Jacksonville	FL
Memorial Hospital of South Broward	Pembroke Pines	FL

HOSPITALS:	CITY	ST
Memorial Regional Hospital	Hollywood	FL
Northwest Florida Community Hospital	Chipley	FL
Park Royal Hospital	Ft. Myers	FL
Santa Rosa Medical Center	Milton	FL
Shands Lake Shore	Lake City	FL
Shands Live Oak	Live Oak	FL
Shands Starke	Starke	FL
West Kendell Baptist Hospital	Kendell	FL
Wuesthoff Medical Center-Rockledge	Rockledge	FL
Wuesthoff Medical Center-Melbourne	Melbourne	FL
Athens Long-Term Acute Care Hospital	Athens	GA
Banks-Jackson-Commerce Hospital and Nursing Home	Atlanta	GA
Grady Memorial Hospital	Atlanta	GA
Hamilton Medical Center	Dalton	GA
Complex Care Hospital of Idaho	Meridian	ID
Advocate Bethany Hospital	Chicago	IL
Advocate BroMenn Regional Medical Center	Normal	IL
Advocate Christ Medical Center	Oak Lawn	IL
Advocate Condell Medical Center	Libertyville	IL
Advocate Good Samaritan Center	Downers Grove	IL
Advocate Illinois Masonic Medical Center	Chicago	IL
Advocate Lutheran General Hospital	Park Ridge	IL
Advocate South Suburban Hospital	Hazel Crest	IL
Elmhurst Memorial Hospital	Elmhurst	IL
Evanston Northwestern Health Care	Evanston	IL
Good Shepherd Hospital	Barrington	IL
Gottlieb Memorial Hospital	Melrose Park	IL
Holy Family Medical Center	Des Plaines	IL
Marshall Browning Hospital	DuQuoin	IL
Mercy Hospital & Medical Center	Chicago	IL
Northwest Community Hospital	Arlington Heights	IL
Our Lady of Resurrection Medical Center	Chicago	IL
Palos Community Hospital	Palos Heights	IL
Provena St. Joseph Hospital	Elgin	IL
Provena St. Mary Hospital	Aurora	IL
Resurrection Medical Center	Chicago	IL
Rockford Memorial Hospital	Rockford	IL
Rush-Copley Medical Center	Aurora	IL
Rush University Medical Center	Chicago	IL

HOSPITALS:	CITY	ST
Saint Anthony Hospital	Chicago	IL
Saint Joseph's Medical Center	Joliet	IL
Sherman Hospital	Elgin	IL
St. Anthony's Memorial Hospital	Effingham	IL
St. Elizabeth Hospital	Chicago	IL
St. Elizabeth Medical Center	Granite City	IL
St. Francis Hospital	Evanston	IL
St. James Hospital & Health Center	Chicago Heights	IL
St. John's Hospital	Springfield	IL
St. Joseph Hospital	Chicago	IL
St. Mary's Hospital	Decatur	IL
St. Mary's Hospital	Kankakee	IL
St. Mary's Hospital	Streator	IL
St. Mary of Nazareth Hospital	Chicago	IL
Swedish American Hospital	Rockford	IL
The Hospital for Specialty Care	Chicago	IL
Bluffton Regional Medical Center	Bluffton	IN
Dukes Memorial Hospital	Peru	IN
DuPont Hospital	Fort Wayne	IN
Elkhart General Hospital	Elkhart	IN
Franciscan Point Saint Anthony Health Complex	Crown Point	IN
Franciscan Physician Hospital	Munster	IN
Heartland Memorial Hospital	Munster	IN
Kosciusko Community Hospital	Warsaw	IN
Lutheran Hospital of Indiana	Fort Wayne	IN
Monroe Hospital	Bloomington	IN
Morgan Hospital and Medical Center	Martinsville	IN
OP Pavilion	Dyer	IN
Pinnacle Hospital	Crown Point	IN
Pulaski Memorial Hospital	Winamac	IN
Rehabilitation Hospital of Fort Wayne	Fort Wayne	IN
Starke Memorial Hospital	Knox	IN
St. Anthony Memorial	Michigan City	IN
St. Francis Hospital - Mooresville	Mooresville	IN
St. Francis Hospitals & Health Centers - South Campus	Indianapolis	IN
St. Joseph Hospital	Fort Wayne	IN
St. Joseph Regional Medical Center	Mishawaka	IN
St. Margaret Mercy Hospital	Hammond	IN
St. Vincent Indianapolis Hospital	Indianapolis	IN

HOSPITALS:	CITY	ST
Shawnee Mission Medical Center	Shawnee Mission	KS
Western Plaines Medical Complex	Dodge City	KS
Jewish Hospital	Louisville	KY
Jewish Hospital Shelbyville	Shelbyville	KY
Southern Kentucky Rehabilitation Hospital	Bowling Green	KY
Avoyelles Hospital	Marksville	LA
Baton Rouge General Medical Center	Baton Rouge	LA
CHRISTUS Coushatta Health Care Center	Coushatta	LA
CHRISTUS Schumpert Highland	Shreveport	LA
CHRISTUS Schumpert St. Mary Place	Shreveport	LA
CHRISTUS St. Francis Cabrini Hospital	Alexandria	LA
CHRISTUS St. Patrick Hospital	Lake Charles	LA
HealthSouth Specialty Hospital of North Louisiana	Ruston	LA
Oakdale Community Hospital	Oakdale	LA
Presbyterian Intercommunity Hospital	Lafayette	LA
River West Medical Center	Plaquemine	LA
Sabine Medical Center	Many	LA
Merrimack Valley Hospital	Haverhill	MA
New Bedford Rehabilitation Hospital	New Bedford	MA
Hillsdale Community Health Center	Hillsdale	MI
St. Joseph Mercy Hospital	Ypsilanti	MI
Truvista Surgery Center	Troy	MI
St. Joseph's Hospital	St. Paul	MN
Cape Girardeau Long-Term Acute Care Hospital	Cape Girardeau	MO
Crossroads Regional Hospital	Wentzville	MO
Franciscan Sisters of Our Lady of Perpetual Help of Ohio	St. Louis	MO
Joplin Long-Term Acute Care Hospital	Joplin	MO
Mineral Area Regional Medical Center	Farmington	MO
Northcrest Regional Medical Center	Kirksville	MO
North Kansas City Hospital	North Kansas City	MO
SSM Regional Health Services	Jefferson City	MO
St. Alexius Hospital - Broadway Campus	St. Louis	MO
St. Alexius Hospital - Jefferson Campus	St. Louis	MO
St. Anthony's Medical Center	St. Louis	MO
St. Mary's Health Center	Jefferson City	MO
St. Mary's Hospital of Blue Springs	Blue Springs	MO
Oxford Lafayette Medical Center	Oxford	MS
Marlton Rehabilitation Hospital	Marlton	NJ
Meadowlands Hospital Medical Center	Secaucus	NJ

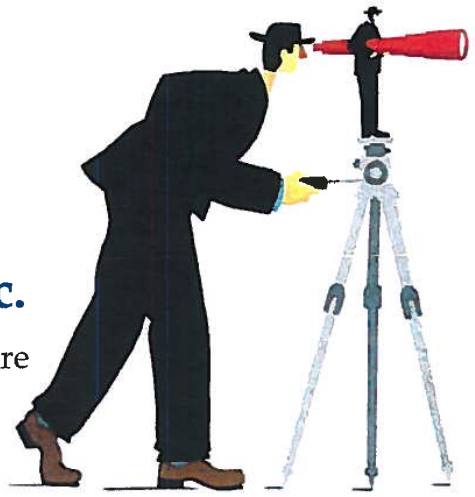
HOSPITALS:	CITY	ST
Memorial Hospital of Salem County	Salem	NJ
Mountainside Hospital	Montclair	NJ
Muhlenberg Medical Center	Plainfield	NJ
St. Michael's Medical Center	Newark	NJ
Presbyterian Hospital	Albuquerque	NM
Presbyterian North Side Hospital	Albuquerque	NM
HealthSouth Hospital at Tenaya	Las Vegas	NV
Deaconess Center	Buffalo	NY
St. Mary's Hospital	Amsterdam	NY
Brown County Regional Hospital	Georgetown	OH
Conneaut Medical Center	Conneaut	OH
Geneva Medical Center	Geneva	OH
Hillside Rehabilitation Hospital	Warren	OH
Mahoning Valley Hospital	Warren	OH
Mahoning Valley Hospital LTAC	Boardman	OH
Select Specialty Hospital	Akron	OH
St. Thomas Hospital	Akron	OH
Summa Health	Akron	OH
Logan Medical Center	Guthrie	OK
Willamette Valley Medical Center	McMinnville	OR
Chestnut Hill Healthcare	Philadelphia	PA
HealthSouth Hospital of Pittsburgh	Monroeville	PA
HealthSouth Regional Specialty Hospital	Mechanicsburg	PA
Lock Haven Hospital	Lock Haven	PA
Memorial Hospital	Towanda	PA
Mercy Hospital	Scranton	PA
Mercy Special Care Hospital – Nanticoke	Nanticoke	PA
Mercy Tyler Hospital	Tunkhannock	PA
Moses Taylor Hospital	Scranton	PA
Southwest Regional Medical Center	Waynesburg	PA
St. Francis Hospital Cranberry	Cranberry	PA
St. Francis Hospital of New Castle	New Castle	PA
St. Francis Medical Center	Pittsburgh	PA
Lookout Memorial Hospital	Spearfish	SD
Sturgis Community Health Care Center	Sturgis	SD
Baptist Hospital of Cocke County	Newport	TN
Fentress County General Hospital	Jamestown	TN
Gateway Medical Center	Clarksville	TN
Haywood Park Community Hospital	Brownsville	TN

HOSPITALS:	CITY	ST
McKenzie Regional Hospital	McKenzie	TN
Mercy Medical Center North	Powell	TN
Mercy Medical Center St. Mary's	Knoxville	TN
Mercy Medical Center West	Knoxville	TN
Methodist Healthcare McNairy	Selmer	TN
Methodist Healthcare Volunteer Hospital	Martin	TN
Methodist Healthcare-Brownsville	Brownsville	TN
Methodist Healthcare-Dyersburg	Dyersburg	TN
Methodist Healthcare-Jackson	Jackson	TN
Methodist Healthcare-McKenzie	McKenzie	TN
Methodist Healthcare-Lexington	Lexington	TN
Middle Tennessee Medical Center	Murphysboro	TN
North Coast Medical Center	Springfield	TN
St. Mary's Jefferson Memorial Hospital	Jefferson City	TN
St. Mary's Medical Center of Campbell County	LaFollette	TN
St. Mary's Medical Center of Scott County	Oneida	TN
White County Community Hospital	Sparta	TN
Baptist Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Children's Hospital	San Antonio	TX
CHRISTUS Santa Rosa Hospital-City Centre	San Antonio	TX
CHRISTUS Santa Rosa Hospital-Medical Center	San Antonio	TX
CHRISTUS Santa Rosa Hospital-New Braunfels	New Braunfels	TX
CHRISTUS Santa Rosa Hospital-Westover Hills	San Antonio	TX
CHRISTUS Spohn Hospital Alice	Alice	TX
CHRISTUS Spohn Hospital Corpus Christi Memorial	Corpus Christi	TX
CHRISTUS Spohn Hospital Corpus Christi South	Corpus Christi	TX
CHRISTUS Spohn Hospital Kleberg	Kingsville	TX
Dell Children's Medical Center	Austin	TX
East El Paso Physicians' Medical Center	El Paso	TX
Gulf Coast Medical Center	Wharton	TX
HealthSouth Hospital of Houston	Houston	TX
Highland Medical Center	Lubbock	TX
LifeCare Hospitals of Ft. Worth	Ft. Worth	TX
LifeCare Hospitals of Plano	Plano	TX
LifeCare Hospitals of San Antonio	San Antonio	TX
Longview Regional Medical Center	Longview	TX
Medical Center of Mesquite	Mesquite	TX
North Central Baptist Hospital	San Antonio	TX
Northeast Baptist Hospital	San Antonio	TX

HOSPITALS:	CITY	ST
Renaissance Hospital of Groves	Groves	TX
Renaissance Hospital of Dallas	Dallas	TX
Renaissance Hospital of Houston	Houston	TX
San Angelo Community Medical Center	San Angelo	TX
Seton Medical Center Williamson	Round Rock	TX
Southeast Baptist Hospital	San Antonio	TX
South Texas Spine & Surgical Hospital	San Antonio	TX
St. Luke's Baptist Hospital	San Antonio	TX
Texas Specialty Hospital	Houston	TX
Trinity Community Medical Center of Brenham	Brenham	TX
Trinity Medical Center	Carrollton	TX
Jordan Valley	West Jordan	UT
Rocky Mountain Medical Center	Salt Lake City	UT
Lee Community Hospital	Pennington Gap	VA
St. Mary's Hospital	Norton	VA
Empire Health Services	Spokane	WA
Lourdes Medical Center	Pasco	WA
St. Joseph Regional Medical Center	Lewiston	WA
Valley Medical Center	Renton	WA
LifeCare Hospitals of Wisconsin	Pewaukee	WI
Aurora Medical Center Grafton	Grafton	WI
Aurora Medical Center Oshkosh	Oshkosh	WI
Aurora Medical Center Summit	Summit	WI
Sacred Heart Hospital	Eau Claire	WI
St. Joseph's Hospital	Chippewa Falls	WI
St. Mary's Hospital Medical Center	Green Bay	WI
St. Nicolas Hospital	Sheboygan	WI
St. Vincent Hospital	Green Bay	WI
Bluefield Regional Medical Center	Bluefield	WV
Charleston Area Medical Center	Charleston	WV
Thomas Memorial Hospital	South Charleston	WV

NAVIGANT
CAPITAL·ADVISORS

Fairness Opinion
Proposal and Qualifications



Greater Waterbury Health Network, Inc.

LHP Hospital Group, Inc./Saint Mary's Hospital Joint Venture

Michael Lane
Managing Director
312.583.2132

Gregory Hagood
Managing Director
404.504.2017

September 28, 2011

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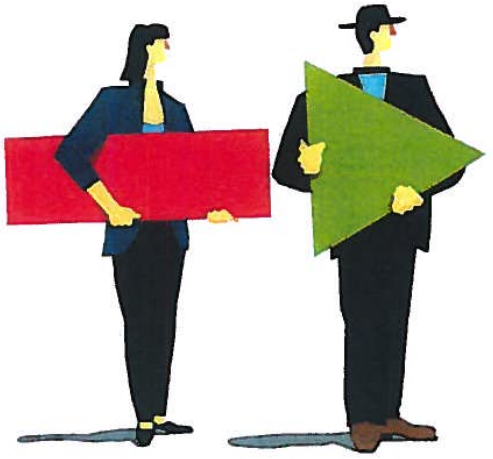
Section 1

Professional Fees/Timeline



Navigant Capital Advisors

Proposed Professional Fees

- Proposed Fixed Professional Fees: [redacted]
  - NCA professional fees are not contingent on the outcome of the opinion
  - Out of pocket expenses will be invoiced separately
- Fairness opinion will be delivered within 45 days of signing an NCA engagement letter containing standard indemnification provisions, and;
  - Will opine on the "fairness", from a financial point of view, of the consideration received in the Transaction which includes the management agreement with an LHP affiliate
  - Will require cooperation from and close working relationship with management
  - Be filed as part of the conversion process application by management
- NCA will NOT opine on, the underlying decision by the Board, relative merits of the transaction, tax or legal aspects of the transaction, solvency or fair value of the Company or any participant to the transaction, the fairness of any portion or aspect of the transaction not expressly addressed in the opinion, or the validity of the information provided in reaching our conclusions.
- Upon signing the engagement letter, NCA will promptly submit a due diligence request list to management requesting certain financial, operational and transactional data and information.
- NCA will comply with the Terms of Engagement as outlined in the request for proposal.

We have conducted our conflict of interest review and have identified <u>NO</u> conflicts to this proposed transaction precluding Navigant Capital Advisors, LLC from rendering a Fairness Opinion

Navigant Capital Advisors

Proposed Timeline

- Week 1: Sign Engagement Letter and submit due diligence request list to Management.
- Week 2: Meet with Board and Management on site for interviews/due diligence/analysis
- Week 3: Conduct due diligence/analysis
- Week 4: Conduct due diligence/analysis/meetings with Management
- Week 5: Complete analysis and presentation and review with Management/Board
  - ➢ Historical Timeline and Overview of the Hospital
    - ✓ Identification of key events
    - ✓ Statistical and operational summary
    - ✓ Payor analysis and summary
    - ✓ Market, demographics and competition
    - ✓ Financial analysis/earnings normalization
  - ➢ Update market and valuation metrics and key considerations
  - ➢ Analysis of Transaction terms and conditions
  - ➢ Summarize results/findings in presentation format
- Week 6: Finalize analysis and Render Fairness Opinion

Section 2

Navigant Capital Advisors Overview

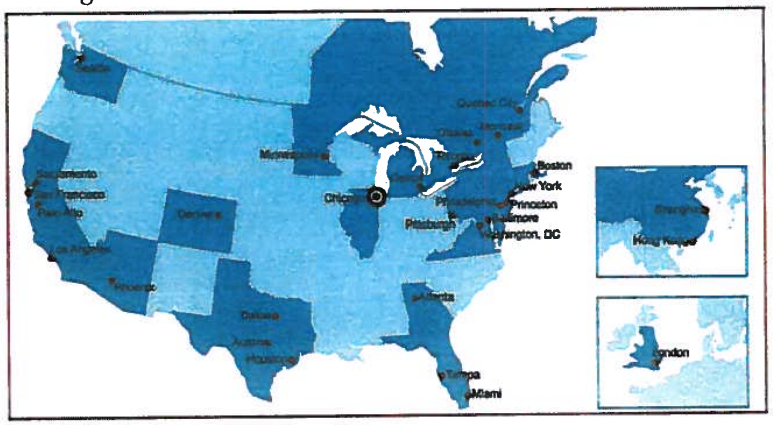
Navigant Consulting
Our Parent

Navigant Consulting, Inc. ("NCI") is the parent company of Navigant Capital Advisors, LLC ("NCA")

Business Description

Navigant Consulting, Inc. is a specialized, independent advisory firm that supports companies, lenders, institutional investors, legal counsel, and government agencies. The company focuses on entities and industries facing the challenges of uncertainty, risk, distress and significant change, and on the issues driving these transformations.

Ticker	NCI (NYSE)
2010 Revenue	$703.7 million
Professionals	1,900+
Headquarters	Chicago, IL



Senior Management

- William M. Goodyear, CEO and Chairman, NCI
- Edward R. Casas, Senior Managing Director, Head of NCA
- Michael lane, Managing Director Healthcare Restructuring
- Greg Hagood, Managing Director, Head of Investment Banking
- David P. Zito, Managing Director, Head of Healthcare Consulting

NCI's 1,900+ professionals maintain presence in 45 cities internationally throughout North America, as well as Europe and Asia.

NAVIGANT
CAPITAL·ADVISORS

Navigant Consulting, Inc.

Business Segment Overview

Our ability to integrate proven advisory skills with industry expertise creates a compelling proposition for our clientele

Navigant Consulting, Inc.

Business Advisory Services

Business advisory services with dominant positions in highly regulated industries including healthcare, energy, construction and insurance and claims.

- Strategic Advisory
- Performance improvement
- Interim Management
- Markets & Transactions
- Technology Strategy & Management
- Financial and Compliance Advisory
- Operations Advisory
- Project Advisory
- Claims Management
- Clinical Improvement
- Insurance Coverage Analysis & Support
- Data & Information Management
- Operations & Systems Consulting / Outsourcing
- Business Process Assessment & Management

Financial Advisory Services (Navigant Capital Advisors)

Full spectrum of financial advisory services with wide industry specialization including: healthcare, manufacturing and distribution, financial services, specialty retail and consumer, business services, energy and construction / real estate.

- Restructuring
  - Capital
  - Operating
- Investment Banking
  - Sell Side
  - Buy Side
  - Private Placement
- Valuation
  - Enterprise Valuations
  - Intangible Assets
- Economic Advisory
  - Anti-trust & Competition
  - Securities Litigation
  - Complex Securities Asset Pricing
  - Detailed Market Analysis

Disputes & Investigations

Litigation, fraud, forensic accounting, investigations, discovery services and government contract dispute services.

- Impact Analysis
- Fact Finding
- SEC Investigations
- Discovery Assistance
- Deposition Support
- Expert Testimony
- Quantifying Losses due to Fraud
- White Collar Criminal Defense
- Electronic Records Management
- Consultation on Financial Reporting Matters
- Special Investigations
- Emerging Contractor Services

NAVIGANT CAPITAL·ADVISORS

Navigant Consulting, Inc.

A Full Spectrum of Healthcare Services

Navigant offers a full spectrum of operational and financial advisory services for healthcare organizations

Strategic Advisory	Operations Advisory and Management	Financial Advisory
Navigant provides healthcare executives with objective, practical, results-oriented assistance to address the business challenges facing their organizations.	Navigant has extensive experience and a successful track record in helping healthcare organizations improve their financial, operational and quality performance.	Navigant offers a full range of financial services and assist healthcare organizations in confronting challenges, identifying solutions and achieving results within a short timeframe.
▪ Enterprise-wide strategic plans ▪ Business plan development and validation ▪ Program and service line analysis ▪ Portfolio analysis and planning ▪ Market research, analysis and forecasting ▪ Product planning, launch and life cycle strategies ▪ Pricing and reimbursement strategy, design and implementation ▪ Public policy evaluation and design ▪ Physician collaboration and integration planning	▪ Comprehensive operational assessment, performance improvement plan development and execution support ▪ Revenue cycle performance improvement ▪ Supply chain management and procurement assistance ▪ Clinical throughput and capacity management ▪ Quality improvement ▪ Physician services and medical staff development ▪ Contract monitoring and oversight ▪ Federal reporting requirements	▪ Due diligence reviews and enterprise valuation ▪ Financial forecasting of policy and program changes ▪ Rehabilitation and performance improvement plan forecasting ▪ Strategic alternatives assessment ▪ Merger, acquisition and divestiture services ▪ Dept capacity analysis and capital restructuring ▪ Recapitalization and rescue financing ▪ Bankruptcy advisory support ▪ Intra-capital structure constituent negotiations

Navigant Consulting, Inc.

A Full Spectrum of Healthcare Services (cont.)

Navigant offers a full spectrum of operational and financial advisory services for healthcare organizations

Interim Management	Risk Mitigation and Compliance	Dispute Resolution and Avoidance
Navigant provides interim leaders to manage healthcare organizations during challenging times, such as transitioning to a new executive, responding to an unexpected departure or absence, managing a turnaround or implementing a merger. Our professionals have the skills, experience and a track record of rapidly achieving desired results.	Navigant offers solutions that enable our clients to function more efficiently and effectively in the ever changing regulatory framework of the healthcare industry.	Navigant offers support services that draw upon both our litigation experience and our wealth of healthcare industry knowledge.
▪ Chief Restructuring Officer ▪ Chief Executive Officer ▪ Chief Implementation Officer ▪ Chief Financial Officer ▪ Chief Operating Officer ▪ Chief Information Officer ▪ Chief Nursing Officer ▪ Vice President Medical Affairs ▪ Other key operational positions	▪ Compliance plan design and implementation ▪ Compliance effectiveness reviews ▪ Regulatory and operating compliance assessment, risk analysis and quantification ▪ Statistical sampling plans for evaluating over/under payments ▪ Billing and reimbursement audits ▪ Voluntary disclosures ▪ Corporate integrity agreement design and implementation ▪ Independent Review Organization ("IRO") services	▪ Document and electronic data discovery efforts, including preparing discovery requests and accumulating, managing and researching document populations ▪ Electronic data warehousing and analysis ▪ Class certification issues ▪ Liability and damage issues ▪ Deposition and trial preparation ▪ Econometric models to identify risk areas and estimate potential damages ▪ Expert testimony in depositions and at trial

NAVIGANT
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Navigant Capital Advisors

A Full Spectrum of Financial Services to the Healthcare Industry

Investment Banking | Valuations & Fairness Opinions | Restructuring

Multidisciplinary Team

NCA team members bring significant transactional, operational, financial and legal experience to all engagements and have broad experience in a wide range of industries.

Market Insight

Through a network of industry, private equity and financing contacts, as well as proprietary data sources, NCA keeps abreast of rapidly changing market environments and industry trends affecting its clients and presenting opportunities and challenges to its stakeholders.

Depth/Breadth of Services

- **Merger and Acquisition Advisory**
  - Exclusive Sale
  - Buy Side Advisory
  - Distressed Asset sale
  - Recapitalizations
  - Corporate Divestiture
- **Private Placements**
  - Institutional Debt
  - Institutional Equity
- **Capital Markets Advisory Services**
- **Corporate Development Services**

- **Fairness Opinions**
- **Financial Reporting**
  - Business valuations
  - SFAS 123 (r), 141, 142, 144
  - Derivatives
  - Intangible Asset Valuations
- **Tax**
  - Section 409A
  - Change in Control Section 382
  - Gift and Estate Tax valuations
  - IRC Section 338

- **Financial & Operational restructuring**
- **Creditor Rights Advisory**
- **Interim and Crisis Management**
- **Bankruptcy Planning and Reorganization**
- **Distressed Real Estate Advisory**

NAVIGANT CAPITAL·ADVISORS

Navigant Capital Advisors

Consistently Ranked as Top Distressed Financial Advisors in The Deal League Tables

Second Quarter 2011

Rank	Adviser	Investment Bank	Active Cases
1	Casas, Edward	Navigant Capital Advisors LLC	12
1	Barrow, J. Gregory	General Capital Partners LLC	12
2	Luria, Neil	Navigant Capital Advisors LLC	10
3	Manning, Jeffrey	BDO Capital Advisors LLC	9
4	Huber, Jack	Navigant Capital Advisors LLC	8
4	Williams, Brent	Duff & Phelps Corp.	8
5	Wu, Christopher	Carl Marks Advisory Group	7
6	Owsley, Henry	Gordian Group LLC	6
7	Caldwell, Patricia	Gordian Group LLC	5
7	Hardie, William	Houlihan Lokey Inc.	5
7	Kaufman, Peter	Gordian Group LLC	5
7	Kurtz, David	Lazard	5
7	Madden, John	Duff & Phelps Corp.	5
7	Murphy, Brendan	Duff & Phelps Corp.	5
8	Decker, James	Morgan Joseph TriArtisan Group	4
8	Feltman, James S.	Mesirow Financial Holdings Inc.	4
8	Geer, Bradley	Houlihan Lokey Inc.	4
8	Henkin, Michael	Jefferies & Co.	4
8	Lattig, Larry H.	Mesirow Financial Holdings Inc.	4

(continued)

2010

Rank	Adviser	Investment Bank	Active Cases
1	Victor, J. Scott	SSG Capital Advisors LLC	13
2	Casas, Edward	Navigant Capital Advisors LLC	12
2	Barrow, J. Gregory	General Capital Partners LLC	12
2	Madden, John	Duff & Phelps Corp.	12
2	Williams, Brent	Duff & Phelps Corp.	12
3	Luria, Neil	Navigant Capital Advisors LLC	10
4	O'Connor, Tim	Broadpoint Gleacher Securities	9
5	Augustine, Neil	Rothschild	8
5	Owsley, Henry	Gordian Group LLC	8
6	Kaufman, Peter	Gordian Group LLC	7
6	Lattig, Larry H.	Mesirow Financial Holdings Inc.	7
6	Murphy, Brendan	Duff & Phelps Corp.	7
6	Ridings, Barry	Lazard	7
7	Belinsky, Russel	Duff & Phelps Corp.	6
7	Derrough, William	Moelis & Co. LLC	6
7	Henkin, Michael	Jefferies & Co.	6
7	Herman, David	Gordian Group LLC	6
7	Huffard, Paul	Blackstone Group LP	6
7	Merola, Frank	Jefferies & Co.	6

(continued)

2009

Rank	Adviser	Investment Bank	Active Cases
1	Madden, John	Chanin Capital / Duff & Phelps	15
2	Murphy, Brendan	Chanin Capital / Duff & Phelps	12
2	Williams, Brent	Chanin Capital / Duff & Phelps	12
3	Lattig, Larry H.	Mesirow Financial Holdings Inc.	11
4	Casas, Edward	Navigant Capital Advisors LLC	9
4	Luria, Neil	Navigant Capital Advisors LLC	9
4	Belinsky, Russel	Chanin Capital / Duff & Phelps	9
4	Kaufman, Peter	Gordian Group LLC	9
5	Barrow, J. Gregory	General Capital Partners LLC	8
5	Carlson, Thomas	Jefferies & Co.	8
5	Herman, David	Gordian Group LLC	8
5	Manning, Jeffrey R.	Trenwith Group LLC	8
6	Derrough, William	Moelis & Co. LLC	7
6	Feltman, James S.	Mesirow Financial Holdings Inc.	7
6	Hardie, William	Houlihan Lokey	7
6	Owsley, Henry	Gordian Group LLC	7
6	Pickering, Ben	Mesirow Financial Holdings Inc.	7
6	Strom, Steve	Jefferies & Co.	7
6	Victor, J. Scott	SSG Capital Advisors LLC	7

(continued)

2008

Rank	Adviser	Investment Bank	Active Cases
1	Casas, Edward	Navigant Capital Advisors LLC	16
2	Luria, Neil	Navigant Capital Advisors LLC	12
2	Feltman, James	Mesirow Financial Holdings Inc.	12
3	Lattig, Larry	Mesirow Financial Holdings Inc.	10
4	Barrow, J. Gregory	General Capital Partners LLC	9
4	Hilty, David	Houlihan Lokey	9
4	Murphy, Brendan	Chanin Capital Partners LLC	9
5	Madden, John	Chanin Capital Partners LLC	8
6	Kaufman, Peter	Gordian Group LLC	7
6	Owsley, Henry	Gordian Group LLC	7
7	Belinsky, Russel	Chanin Capital Partners LLC	6
7	Victor, J. Scott	National City Corp.	6
8	Augustine, Neil	Rothschild	5
8	Burian, Saul	Houlihan, Lokey, Howard &	5
8	Derrough, William	Moelis & Co. LLC	5
8	DiMauro, Chris	Houlihan, Lokey, Howard &	5
8	Manning, Jeffrey R.	Trenwith Group	5
8	Miller, Henry S.	Miller Buckfire & Co. LLC	5
8	Siegert, Eric	Houlihan, Lokey, Howard &	5

(continued)

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Source: The Deal.com Bankruptcy League Tables. Rankings include all debtor, creditor and other assignments within active bankruptcy cases.

Navigant Capital Advisors

Acute Care Hospital Experience

- NCA has orchestrated multiple competitive bidding auction processes for the sale of acute care hospitals and related assets associated with healthcare delivery systems
- Extensive experience with sales of not-for-profit hospitals
  - In-depth knowledge of various affiliation arrangements, capital structures , and regulatory issues, including conversions
- Relevant Experience:
  - Identifying and advising Hospital Boards with regard to strategic options
  - Positioning hospital assets for sale
  - Working with physicians, employees and other stakeholders to identify and manage needs and concerns
  - Identification of conflicts and regulatory issues
  - Oversight of competitive auction processes
  - Identification of industry and market dynamics

NAVIGANT CAPITAL·ADVISORS

Navigant Capital Advisors

NCA Recent Not-for-Profit Hospital Transactions

Healthcare System	Description	Transaction	NCA Role
Caritas Christi Healthcare System	Owner of six 501(c)3 Catholic hospitals in Eastern MA	Sale of non-profit hospitals to Cerberus Capital Management and conversion to for-profit status.	Financial advisor engaged to review transaction terms and conditions and issue a Fairness Opinion. Navigant was initially retained to provide a strategic review and assessment related to identifying capital alternatives for this non-profit organization
Sumner Regional Healthcare System	Three 501(c)3 hospital healthcare organization serving eleven counties in middle Tennessee	Sale of non-profit hospitals to Lifepoint Hospital Corporation pursuant to Section 363 under Chapter 11 of the U.S. Bankruptcy Code and conversion to for-profit status.	Financial advisor in bankruptcy and in connection with exploring strategic alternatives; also served as interim management. NCA led a competitive sale process whereby numerous offers were obtained and negotiated with a wide array of national and regionally-focused hospital companies.
Twin City Hospital System	A twenty-five bed, not-for-profit 501(c)3, critical access hospital located in Dennison, Ohio	Sale to hospital Franciscan Services Corp. pursuant to section 363 under Chapter 11 of the U.S. Bankruptcy Code.	Financial advisor in connection with exploring strategic alternative and managing auction process.
Morton Hospital and Medical Center	154-bed not-for-profit 501(c)3 acute care hospital offering a full spectrum of medical and surgical services located in Taunton, MA	Sale of non-profit hospital to Steward Health Systems and conversion to for-profit status.	Financial advisor in connection with exploring strategic alternatives including identifying a capital or affiliation partner. **Navigant was initially retained to provide a strategic review and assessment related to identifying capital alternatives. Structured transaction and worked through issues with the Attorney General.**
Tomball Regional Medical Center	Municipal hospital in Tomball, Texas with 358 licensed beds and a medical staff of over 360 physicians	Sale of non-profit hospital to Community Health Systems (NYSE: CYH) and conversion to for-profit status.	Financial advisor for managing a competitive process to identify strategic alternatives including the sale of the hospital and other non-core assets and worked through conversion process.
Quincy Medical Center ("QMC")	Not-for-profit 501(c)3 acute care community hospital located in Quincy, MA with 196 licensed beds and over 340 physicians	Sale of non-profit hospital to Steward Medical Holdings (pending) pursuant to Section 363 under Chapter 11 of the U.S. Bankruptcy Code, and conversion to for-profit status.	Financial advisor for i) managing a competitive process to identify strategic alternatives including the sale of the hospital and other non-core assets, ii) negotiating with QMC's bondholders and other creditors regarding financial restructuring matters.

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Navigant Capital Advisors

Leading Investment Bankers for Healthcare – recent transactions

$830,000,000
Caritas
has been acquired by
Cerberus
Financial Advisor

$48,000,000
Morton Hospital & Medical Center
Is being acquired by
Steward Medical Holdings
Pending
Sell Side Advisor

$156,000,000
Sumner Regional Health Systems, Inc.
Financial Advisor,
Chief Executive Officer
Chief Restructuring Officer

$38,000,000
Quincy Medical Center
is being acquired by
Steward Medical Holdings
Pending
Sell Side Advisor

MedCath
MedCath Corporation
(Nasdaq: MDTH)
Financial Advisor

$76,250,000
TexSan Heart Hospital
has been acquired by
Methodist Healthcare
System of San Antonio
Sell Side Advisor

Tomball Regional Medical Center
Is being acquired by
Community Health
Systems
Pending
Sell Side Advisor

$32,000,000
Arizona Heart Hospital
has been acquired by
Vanguard Health Systems
Sell Side Advisor

Riverview Regional Medical Center
has been acquired by
LifePoint Hospitals
Sell Side Advisor

$7,000,000
An equity interest in
Southwest Arizona Heart and Vascular Center, LLC
has been acquired by
its physician partners
Sell Side Advisor

Brotman Medical Center
Financial Advisor,
Chief Executive Officer and
Chief Restructuring Officer

$20,000,000
An equity interest in
Avera Heart Hospital of South Dakota
has been acquired by
Avera McKennan
Sell Side Advisor

Trousdale Medical Center
has been acquired by
LifePoint Hospitals
Sell Side Advisor

$83,800,000
Heart Hospital of Austin
has been acquired by
St. David's Healthcare
Partnership, L.P.
Sell Side Advisor

$939,000,000
BCM
Baylor College of Medicine
Financial Advisor

Navigant Capital Advisors

Key Qualifications

- NCA has developed its fairness opinion practice based on "best practices" and decades of experience:
  - NCA professionals have extensive experience advising Boards of Directors and independent/special committees
  - Truly independent financial advisor
  - Procedures and documentation incorporate existing and proposed rules and regulations
  - Rigorous review of prospective projects
  - Deliberate assignment of each execution team based on skill set
  - Independent stature of Fairness Opinion Operating Committee—approvals and reviews
  - Members of the execution team and Fairness Opinion Operating Committee have both technical and transaction experience

Navigant Capital Advisors

Fairness Opinion Capabilities

Fairness Opinion Practice	As part of Navigant's Valuation Services practice, we have a fully integrated Fairness Opinion practice. Our practice conforms to applicable FINRA standards for independence and internal reviews to assure a rigorous, well-researched conclusion for our clients.
Level of Sophistication	We have significant experience executing transactions for publicly traded companies including cross-border acquisitions, divestitures, reverse mergers and complex second lien financings.
Senior Level Attention	Navigant Capital Advisor's Senior Professionals are well seasoned with significant transactional experience who will manage your transaction from initiation to close.
Full Service Advisory Firm	We provide a comprehensive and integrated suite of advisory services including sell-side representation, capital sourcing of debt and equity, corporate assessments, strategic advisory, financial restructuring, fairness opinions and due diligence services.
Financial Strength	With an enterprise value exceeding $700 million and a market capitalization of approximately $500 million, NCI has the financial strength to stand with its clients even years from now.

Section 3

Benefits of Fairness Opinion

Benefits of a Fairness Opinion

When Does a Fiduciary Need a Fairness Opinion?

- Fairness opinions are not required by any statute or regulation, but they have become a regular feature of corporate transactions since 1985 when the Delaware Supreme Court issued its Opinion in Smith v. Van Gorkum.
- The Court found that a corporate board breached its fiduciary duty of care by approving a merger without *adequate information on the transaction,* including information on *the value of company* and *the fairness of the offering price.*
- It was not the price itself that was questioned, only that *there was no independent evidence* that that the price was fair.
- Fairness Opinions serve two main purposes:
  - Provide boards of directors or trustee with information which to evaluate a transaction; and;
  - Serve as evidence in litigation that the board of directors used reasonable business judgment in approving the transaction

Benefits of a Fairness Opinion

When Does a Fiduciary Need a Fairness Opinion?

- Corporate boards of directors or trustees frequently obtain an independent opinion to assess the fairness of certain contemplated transactions having a significant impact on an organization's value.
- Fairness opinions are generally rendered for the following transactions:
  - Mergers and acquisitions
  - Employee Stock Ownership Plans (ESOP)
  - Going private transactions with Equity private placements
  - **Not-For–Profit Conversions**
- Issues for which Fairness Opinions are generally recommended include:
  - A fiduciary wants an independent advisor to support its actions
  - Tender offer, sale or merger is conducted without an auction
  - Minority shareholders are being bought out
  - Significant change in capital structure
  - Prospects of dilution
  - Management, board members, or controlling holders benefit from the transaction
  - Multiple constituencies or shareholders

Benefits of a Fairness Opinion

What is included in a Fairness Opinion?

- Fairness opinions historically have been delivered in the form of a letter addressed to:
  - A company's Board of Directors
  - A special committee of independent directors formed to consider a proposed transaction
  - Trustees or other fiduciaries responsible for evaluating a corporate transaction
- The opinion is backed by a supporting presentation detailing the methods used and the analysis leading to the conclusion.
- Fairness Opinions typically include the following
  - Description of the proposed transaction;
  - Summary of the financial advisor's due diligence investigation;
  - Statement of any limitations on use;
  - Statement of conclusion (example, that the proposed transaction or consideration received is fair, from a financial point of view).

Benefits of a Fairness Opinion

What is included in a Fairness Opinion?

- A Fairness opinions is:
  - A financial advisor's opinion that states whether or not the financial terms of a proposed transaction are within a range of fairness;
  - Expressed from a financial point of view to one or more specific parties of the proposed transaction as of a specific date.
- A Fairness opinions Is NOT:
  - An opinion that the proposed transaction is fair from a legal point of view;
  - A recommendation for the proposed transaction;
  - An evaluation of the business rationale to proceed with a transaction.

Benefits of a Fairness Opinion

What is Considered in Rendering a Fairness Opinion?

- In preparing a fairness opinion, financial advisors must:
  - Utilize proven valuation techniques;
  - Implement thorough industry analysis and extensive due diligence
  - Include a rigorous analysis of the available alternatives to the proposed transaction
- Key question is "Are the shareholders or beneficiaries better off with or without the proposed Transaction?"
- In a cash transaction, an advisor should analyze whether the consideration to be paid falls within the fairness range and what alternatives exist.
- In a transaction involving a non-cash exchange, an advisor should consider the relative benefits to the selling organization's stakeholders owning the buyer's stock.
- The following are NOT a consideration:
  - Is a better deal available?
  - Are there Anti-Trust concerns?

Benefits of a Fairness Opinion

What is Considered in Rendering a Fairness Opinion?

- All types of consideration must be valued, including management contract fees, contingent payments and percentage ownership in a joint venture.
- A financial advisor must analyze:
  - The relative consideration received by various parties;
  - *Other financial terms of the transaction*
  - Any financial alternatives that may be available to the shareholders or beneficiaries
- High level of due diligence are required for:
  - History of the transaction
  - Marketing of the deal
  - Projections
- No formal standard of value exists for the preparation of Fairness Opinions.
- It is necessary to consider all the material facts and circumstances of the proposed transaction when determining the standard of value.

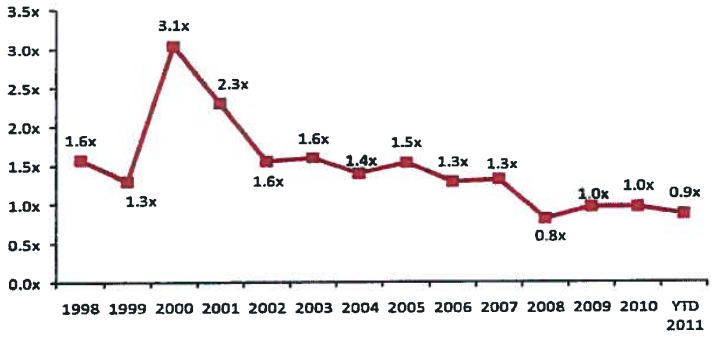
Section 4

Market Overview

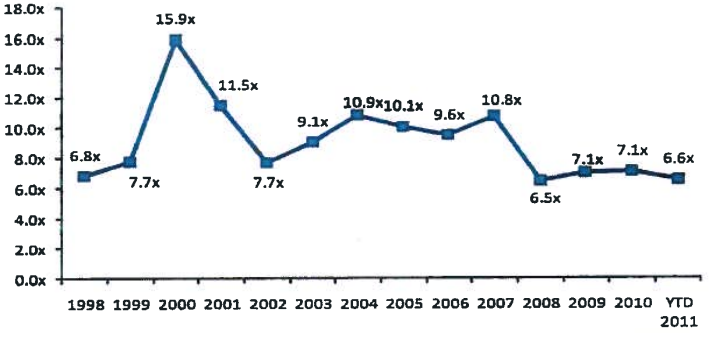
Current Hospital Valuation Trends

Valuation Trends for Publicly Traded Hospital Companies

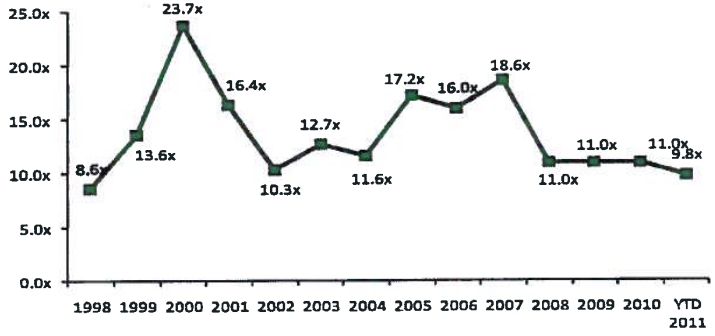
Enterprise Value / Revenue



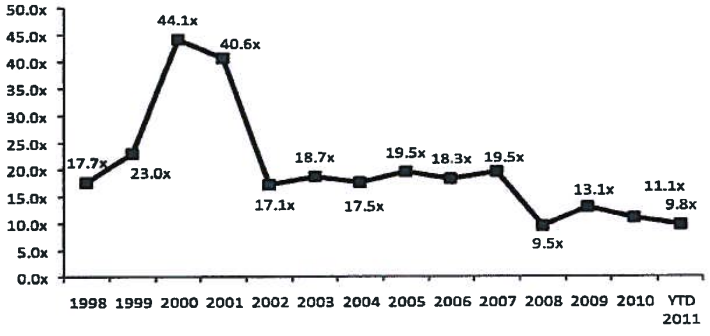
Enterprise Value / EBITDA



Enterprise Value / EBIT



Price to Earnings



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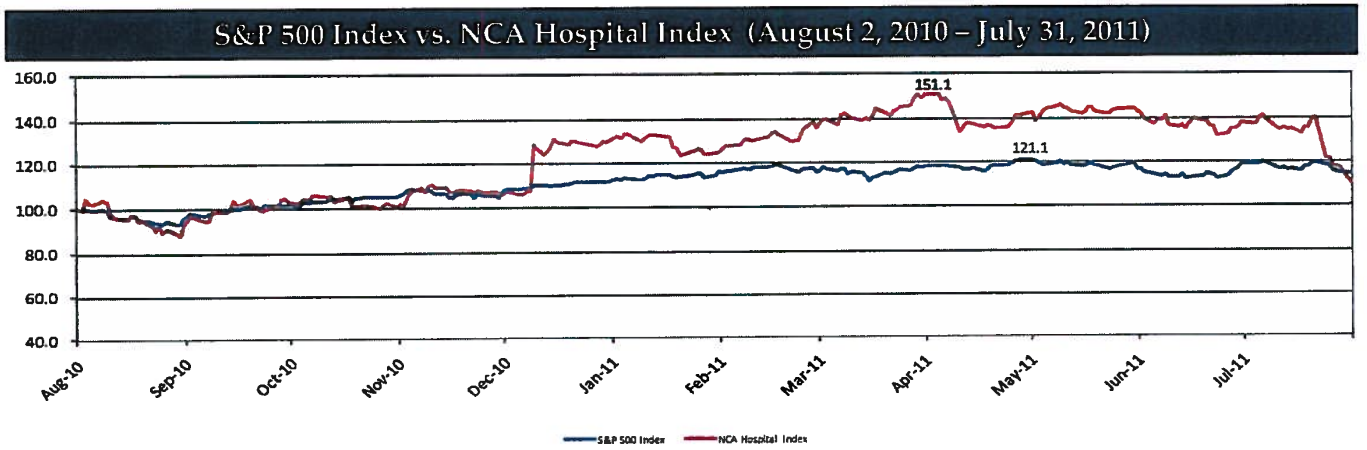
Note: The graphs are representative of the companies within the "NCA Hospital Index" which includes CYH, HMA, LPNT, THC, and UHS. Source: Capital IQ

Current Hospital Valuation Trends

Comparable Companies Publicly Traded

- Publicly Traded Hospitals currently trade at a median multiple of 0.9x revenue and 6.6x EBITDA



($ in millions, except per share data)		Stock Price	% of 52 Wk	Enterprise	Latest Twelve Months (LTM)			Cal Year 2011		Enterprise Value/ LTM		CY 2011	
Company Name	Ticker	8/1/11	High	Value	Revenue	EBITDA	EBITDA %	Revenue	EBITDA	Revenue	EBITDA	Revenue	EBITDA
Community Health Systems, Inc.	CYH	$24.36	57%	$11,666	$13,625	$1,710	12.5%	$14,755	$1,929	0.9x	6.8x	0.8x	6.0x
HCA Holdings, Inc.	HCA	$24.94	71%	38,788	31,501	5,566	17.7%	34,318	6,336	1.2x	7.0x	1.1x	6.1x
Health Management Associates Inc.	HMA	$8.96	76%	5,023	5,442	781	14.4%	6,219	884	0.9x	6.4x	0.8x	5.7x
Lifepoint Hospitals Inc.	LPNT	$35.57	82%	3,178	3,452	541	15.7%	3,789	574	0.9x	5.9x	0.8x	5.5x
Tenet Healthcare Corp.	THC	$5.44	71%	6,881	9,443	1,140	12.1%	10,137	1,295	0.7x	6.0x	0.7x	5.3x
Vanguard Health Systems Inc.	VHS	$16.33	88%	3,054	4,896	404	8.2%	6,530	569	0.6x	7.6x	0.5x	5.4x
High:										**1.2x**	**7.6x**	**1.1x**	**6.1x**
Low:										**0.6x**	**5.9x**	**0.5x**	**5.3x**
Mean:										**0.9x**	**6.6x**	**0.8x**	**5.7x**
Median:										**0.9x**	**6.6x**	**0.8x**	**5.6x**

Source: Capital IQ

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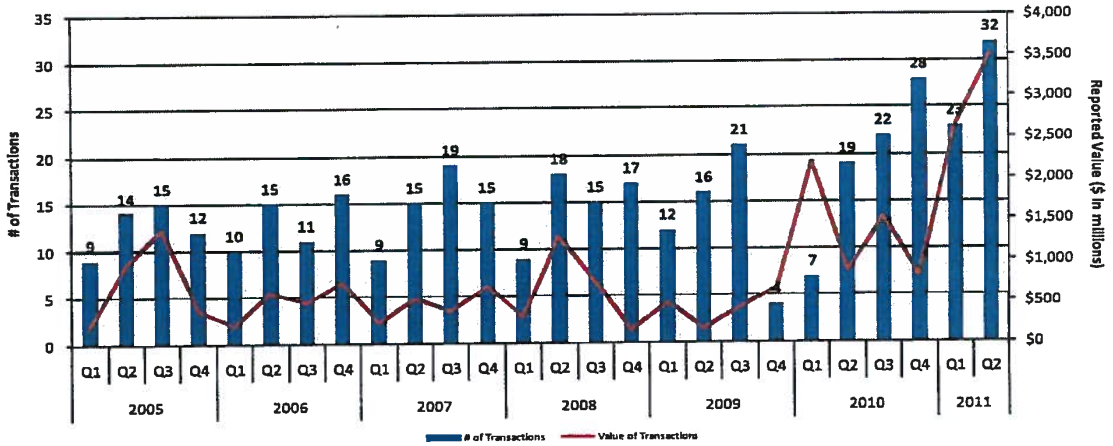
Current Hospital Valuation Trends

Recent Hospital M&A Activity

- Hospital M&A Activity has increased over past year due to:
  - Recessionary impact on community owned hospitals
  - Increasing capital investment required to remain competitive
  - Favorable valuations

Hospital M&A Transactions by Quarter



Notable Transactions:

[1] In Q3 2006, the privatization of HCA, Inc. by a private equity consortium affected 176 acute-care hospitals. The acquisition was the largest healthcare transaction ever announced at approximately $33.0 billion. This acquisition is not included above.

[2] In Q1 2007, Triad Hospitals, Inc. was acquired by Community Health Systems, Inc. (NYSE: CYH) for approximately $6.8 billion. This acquisition is not included above.

[3] Q1 2010 value includes the acquisition of Detroit Medical Center by Vanguard Health Systems, Inc. for approximately $1.267 billion.

[4] Q4 2010 value does not include the acquisition of Tenet Healthcare by Community Health Systems for approximately $7.3 billion.

Source: Irving Levin Associates, Inc.

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Current Hospital Valuation Trends

Comparable Precedent Transactions

- Based upon 41 publicly disclosed hospital acquisitions from 2010 and 2011, acquisition multiples imply median values of 0.68x revenue and 6.7x EBIDA, respectively.

($ in millions, except price per bed)

			Whole Company Transactions Method Multiples							
			Target					Transaction	Transaction Value [2]	
Date	Buyer	Target	ST	Status	Revenue	EBIDA [1]	Beds	Value	Revenue	EBIDA	Bed
08/28/11	Kingman Regional Medical Center	Hualapai Mountain Medical Center	AZ	For Profit	NA	NA	70.0	31.0	NA	NA	442,857
07/25/11	Duke LifePoint Healthcare, LLC	Maria Parham Medical Center	NC	For Profit	97.8	11.9	102	76.6	0.8x	6.4x	750,980
07/01/11	Health Management Associates, Inc.	Mercy Health Partners, Inc.	TN	Nonprofit	600.0	NA	833.0	525.0	0.9x	NA	630,252
06/15/11	HCA, Inc.	Remaining interest in HealthONE	CO	For Profit	NA	NA	1,500	1,450.0	NA	NA	966,667
06/07/11	Steward Health Care System	Landmark Medical Center	RI	Non-profit	NA	NA	203.0	76.6	NA	NA	377,340
05/25/11	University of Maryland Medical System	Civista Health System	MY	Non-profit	103.8	NA	130	16.5	0.2x	NA	126,923
05/18/11	LifeCare Holdings, Inc.	Six long-term acute care hospitals	AL	For Profit	121.7	17.5	414.0	120.0	1.0x	6.9x	289,855
05/13/11	South Georgia Medical Center	Smith Northview Hospital	GA	For Profit	41.4	6.1	45	40.0	1.0x	6.6x	888,889
05/10/11	Franciscan Services Corp.	Twin City Hospital	OH	Non-profit	15.8	NA	25.0	4.9	0.3x	NA	196,000
05/09/11	AR-MED, LLC	Arkansas Heart Hospital	AK	For Profit	117.5	17.4	112	60.0	0.5x	3.4x	535,714
04/25/11	HUMC Holdco	Hoboken University Medical Center	NJ	Non-profit	115.3	NA	230.0	91.7	0.8x	NA	398,696
04/20/11	Health Management Associates, Inc.	Tri-Lakes Medical Center	MS	For Profit	30.3	NA	112	39.0	1.3x	NA	348,214
04/18/11	Adventist Health	Sierra Kings District Hospital	CA	Non-profit	22.1	NA	44.0	24.8	1.1x	NA	563,636
03/31/11	Sabra Health Care REIT	Texas Regiona Medical Center	TX	For Profit	NA	NA	70	62.7	NA	NA	895,714
03/25/11	Yale-New Haven Hospital	Hospital of Saint Raphael	CT	Non-profit	450.3	15.4	511.0	135.0	0.3x	8.8x	264,188
03/18/11	Iasis Healthcare	St. Joseph's Medical Center	TX	Non-profit	245.0	NA	792	156.8	0.6x	NA	197,980
03/09/11	Franciscan Services Corp.	Twin City Hospital	OH	For Profit	15.8	NA	25.0	4.9	0.3x	NA	194,000
03/04/11	Trinity Health Corporation	Loyal University Health System	IL	Non-profit	1,100.0	NA	820	475.0	0.4x	NA	579,268
02/23/11	Steward Health Care System	Jackson Health System	FL	Non-profit	NA	NA	2,482.0	1,100.0	NA	NA	443,191
02/10/11	Community Health Systems, Inc.	Mercy Health Partners	PA	Non-profit	183.9	NA	313	150.0	0.8x	NA	479,233
02/01/11	UPMC Health System	Harrot Medical Center	PA	Non-profit	315.2	33.0	351.0	300.0	1.0x	9.1x	854,701
01/17/11	Sisters of Mercy Health System	Johnston Memorial Hospital	OK	Non-profit	3.8	NA	15	1.6	0.4x	NA	106,667
12/21/10	Hospital Authority of Albany-Dougherty	Palmyra Park Hospital	GA	For profit	166.5	NA	248.0	195.0	1.2x	NA	786,290
12/21/10	Medical Properties Trust Inc.	Three Long-Term Acute Care Hospital Facilities	Various	For Profit	NA	NA	220	99.5	NA	NA	452,273
12/20/10	Healthcare Trust of America, Inc.	Multi-state Portfolio	Various	For profit	NA	NA	209.0	102.0	NA	NA	488,254
12/10/10	Grubb & Ellis Healthcare REIT II, Inc.	Humble Surgical Hospital, LLC	TX	For profit	NA	NA	NA	13.1	NA	NA	NA
11/17/10	Prime Healthcare Services, Inc.	Alvarado Hospital Medical Center, Inc.	CA	For profit	176.4	6.1	2,437.0	40.0	0.2x	6.6x	16,414
10/26/10	Vibra Healthcare, LLC	Two Indiana LT Acute Care Hospitals	IN	For Profit	NA	NA	NA	21.0	NA	NA	NA
10/26/10	Vibra Healthcare, LLC	Two Ohio LT Acute Care Hospitals	OH	For Profit	NA	NA	NA	21.0	NA	NA	NA
10/12/10	ThedaCare	Shawano Medical Center	WI	Non-profit	NA	NA	25	4.3	NA	NA	172,000
10/11/10	SUNY Downstate Medical Center	Long Island College Hospital	NY	For profit	NA	NA	506.0	110.0	NA	NA	217,391
10/01/10	New Directions Health Systems, LLC	Pike County Memorial Hospital	AR	Non-profit	3.5	0.2	32	2.0	0.6x	8.1x	62,500
09/10/10	Iasis Healthcare	Brim Holdings	TN	For profit	NA	NA	165.0	95.0	NA	NA	575,758
09/02/10	Adventist Health Systems, Inc.	University Community Health, Inc.	FL	Non-profit	502.5	NA	NA	353.0	0.7x	NA	NA
09/01/10	Health Management Associates, Inc.	Wuesthoff Health System	FL	Non-profit	290.0	NA	406.0	151.5	0.5x	NA	373,153
08/30/10	Avera MacKennan	Avera Heart Hospital	SD	For profit	NA	NA	55	36.0	NA	NA	654,545
08/24/10	Kindred Healthcare Inc.	Five Long Term Acute Care Hospitals	CA	For profit	150.0	27.0	250.0	178.0	1.2x	6.6x	712,000
08/16/10	Management	Prospect Medical Holdings, Inc.	CA	For profit	468.0	54.0	759	363.0	0.8x	6.7x	478,261
08/09/10	Vanguard Health Systems, Inc.	Arizona Heart Hospital	AZ	For profit	NA	NA	58.0	32.4	NA	NA	549,153
08/06/10	Community Health Systems, Inc.	Forum Health	OH	Non-profit	300.4	NA	625	200.0	0.7x	NA	320,000
08/06/10	MHA, LLC	Meadow lands Hospital	NJ	Non-profit	61.6	NA	230.0	16.0	0.3x	NA	69,565

High	1.29x	9.09x	$986,667
Low	0.15x	3.45x	$16,414
Mean	0.66x	6.91x	$444,825
Median	0.68x	6.66x	$443,191

Notes:

[1] For-profit hospital data is before taxes, thus comparable to EBIDA.

[2] High, mean, and median metrics exclude EBIDA multiples > 11x, per Bed multiples > $1 mil.

Source: Irving Levin Associates, Inc, CapitalIQ.

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Section 5

Healthcare Solutions Leadership Team

Healthcare Solutions Leadership Team

Key Member Biographies

EDWARD R. CASAS, MD, MBA, MPH
SENIOR MANAGING DIRECTOR
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847.583.1619

Edward R. Casas serves as Senior Managing Director and Head of Navigant Capital Advisors. Dr. Casas specializes in financial restructurings, corporate finance, mergers, acquisitions and divestitures and strategic plan development on behalf of creditors, debtors, equity sponsors, third party purchasers and sellers. As Senior Managing Director and Founding Member of Casas, Benjamin & White, LLC (CBW), which was acquired by Navigant in 2005, Dr. Casas supervised and coordinated the strategy and focus for all aspects of the firm's restructuring engagements, including the assessment of management and operations, the development of business strategy, and the negotiation and execution of capital and operating restructuring initiatives. Over the past 20 years, he has led numerous merger, acquisition and divestiture transaction, as well as reorganizations, in a breadth of industries including healthcare, real estate, construction, hedge funds and other financial institutions, consumer and business services, manufacturing and distribution, entertainment, and technology.

Prior to founding CBW, Dr. Casas served as President and Chief Executive Officer of PrimeCare International, Inc. where he successfully orchestrated the operating and capital restructuring of the national, privately held corporation, ultimately achieving a targeted liquidity objective for the shareholders. Prior to joining PrimeCare, Dr. Casas had national responsibility as Vice President of Mergers & Acquisitions for Caremark International, Inc. a publicly traded (NYSE) Fortune 500 Company. Dr. Casas joined Caremark after he completed his active duty service as a designated Flight Surgeon in the U.S. Navy where he provided support to Marine special operations and served as a Department Head of Aviation Medicine. Before his medical training, Dr. Casas was Executive Vice President of CES Corporation, a specialized investment banking concern.

Dr. Casas has served on the boards of numerous public and private companies, including Reckson Associates, Inc. (NYSE: RA), a $5 billion market cap New York based REIT, and Physician Specialty Corp. (NASDAQ: ENT), an Atlanta based operator of professional services and MedCath Corporation (NASDAQ:MDTH), a healthcare provider focused primarily on the diagnosis and treatment of cardiovascular disease. He has served as Executive Chairman of HQ Global Workplaces, Inc., the largest domestic operator of executive office suites, Mediq, Inc., one of the largest medical equipment related companies, and Tender Loving Care Healthcare Services, Inc., the third largest domestic homecare service operator.

Dr. Casas is a graduate of Northwestern University's Medical School and Kellogg Graduate School of Management where he concurrently earned his Doctor of Medicine, Master of Management, and Master of Public Health degrees. Dr. Casas is a FINRA Series 7, 24 and 63 licensed registered securities principal. He also holds a CIRA certification as a Certified Insolvency & Restructuring Advisor.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

MICHAEL R. LANE
MANAGING DIRECTOR
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Michael Lane is a Managing Director in Navigant Capital Advisors' Healthcare practice. He has been involved with the healthcare industry throughout his career for over 30 years, primarily as a financial advisor in troubled situations, a banker and consultant. At Navigant Capital Advisors, he is devoted full time to the healthcare industry with an emphasis on the acute care sector. His areas of specialization include mergers and acquisitions and serving as an advisor to distressed and underperforming healthcare organizations, representing equity sponsors and creditors including banks, bondholders and unsecured committees in evaluating various strategic alternatives in financial restructurings and workouts. Recent engagements include serving as CRO at Catskill Regional Medical Center, Harris, NY, and interim CEO/CRO at Brotman Medical Center, Culver City, CA. In addition, Mr. Lane has been involved with some very high profile M&A transactions including the acquisition of six Catholic Hospitals in Boston, by Cerberus.

Among the recent hospital clients for which Mr. Lane has provided financial advisory services include :

- Caritas Christi Healthcare
- Madison Hospital Center
- Morton Hospital and Medical Center
- Tomball Regional Medical Center
- Brotman Medical Center

He has been involved with mergers and acquisitions over the past 20 years aggregating several billion dollars.

Mr. Lane is a licensed CPA and a member of the AICPA, Illinois CPA Society, the American Bankruptcy Institute and Turnaround Management Association. He is FINRA series 7 and 63 licensed and holds an AIRA certification as a Certified Insolvency and Restructuring Advisors. He holds a Bachelor of Science degree and an MBA from Southeast Missouri State University.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

GREGORY F. HAGOOD
INVESTMENT BANKING PRACTICE LEADER
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Gregory F. Hagood, CFA is a Managing Director and Practice Group Leader for the Investment Banking Group at NCA where he focuses on providing mergers and acquisitions advisory services and distressed sale and asset liquidation services. During the past decade, he has completed over 100 merger & acquisition and capital placement transactions. Mr. Hagood has extensive transaction experience in the healthcare industry including hospitals, physician practices, healthcare staffing, revenue cycle management and healthcare technology industries.

Currently Mr. Hagood is advising on the disposition of numerous hospital and other healthcare assets in connection with the wind-down of a publicly-traded healthcare system.

Among the recent hospital clients for which Mr. Hagood has provided merger & acquisition advisory services include :

- Caritas Christi Healthcare
- MedCath Corporation
- Morton Hospital and Medical Center
- Tomball Regional Medical Center.
- Quincy Medical Center.

Mr. Hagood received his Master's of Management from the J.L. Kellogg School of Management at Northwestern University and earned a Bachelor of Science degree from the McIntire School of Commerce at the University of Virginia. He is FINRA Series 7, 24 and 63 licensed and is also a Charter Financial Analyst (CFA) and a member of the Atlanta Society of Financial Analysts.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

DAVID P. ZITO
MANAGING DIRECTOR
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David P. Zito is a Managing Director and serves as practice leader of the Healthcare practice of Navigant Consulting. Mr. Zito has over 20 years of management consulting experience serving integrated healthcare systems, public and private teaching institutions, academic medical centers, faculty practice plans and community hospitals. He has extensive experience in operations improvement, strategic planning, mergers and acquisitions, supply chain management and clinical transformation and specializes in these areas.

Over his career, Mr. Zito has provided a variety of healthcare consulting services such as the manager of a health care system implementation and directed a $150 MM operations improvement initiative at UPMC Health System in Pennsylvania, a $200 MM improvement plan including productivity improvement, supply chain and revenue cycle management, and clinical program redesign for Continuum Health Partners in New York, a $100 MM performance improvement plan at Memorial Hermann Health System in Texas, and also led the post-merger integration planning, and directed the implementation for a $50M performance improvement plan.

Mr. Zito has also led the development of performance improvement plans for other health systems including University Health System in Ohio, Health Alliance in Ohio, Jewish Hospital Health System in Kentucky, St Francis in Peoria, Long Island Jewish, and Phoenix Children's.

Prior to joining Navigant Consulting, Inc., Mr. Zito was a Vice President for Cap Gemini Ernst & Young's Healthcare Consulting practice. During his time at CGEY, he held several leadership positions including, Healthcare Business Unit Leader, Service Line Leader, and Strategy & Operations Service Line Leader.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

DAVID BURIK
MANAGING DIRECTOR
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David Burik is a Managing Director with Navigant Consulting's healthcare team. He has over 30 years of consulting experience within all segments of the health care industry. His expertise includes the definition and communication of key strategic issues, market and demographics, competitor analysis, as well as the successful execution of the solutions for those issues. Mr. Burik's creativity, listening skills, and ability to respectfully challenge clearly summarize the key issues at hand and facilitate decision making, are recognized throughout the healthcare industry.

Prior to joining Navigant, Mr. Burik spent a majority of his career at Tiber Group and Price Waterhouse. Mr. Burik received his undergraduate degree at Northwestern University and a masters degree in Finance and Hospital Health Services Management from the Kellogg School of Management at Northwestern University. David is an editorial reviewer for the Hospital Financial Management Association and was a recipient of the Follmer Bronze Merit Award.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

KIM BRADY
MANAGING DIRECTOR
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847.583.1718

Kim Brady is a Managing Director with Navigant Capital Advisors and specializes in capital restructuring and operational turnaround on behalf of the firm's clients. He has significant experience negotiating with senior secured creditors, overseeing asset divestitures and dispositions, rehabilitating under-performing companies and executing distressed mergers and acquisitions. While at Navigant Capital Advisors, Mr. Brady has structured and overseen the successful disposition of over 150 business units and has consummated over $5 billion in debt restructuring and $1.5 billion in M&A transactions with an emphasis in the healthcare services, real estate, consumer services, construction, distribution, technology, and basic manufacturing industries.

Mr. Brady works closely with private equity firms, senior secured creditors, unsecured creditors, boards of directors and company management in executing capital and operational restructuring. He has led engagements both in-court and out-of-court. Recent engagements have involved the restructuring of healthcare services, continuing care retirement communities, home nursing, dental management and retail companies. Mr. Brady is skilled in developing capital restructuring solutions and operating initiatives to drive management accountability and to improve profitability and liquidity. He has held a number of interim management roles in the client companies, such as CFO and CRO, in which significant performance improvements were realized, resulting in 100% recovery for capital structure constituents and in the creation of significant equity value for the sponsor.

Before joining Casas, Benjamin & White, LLC, a predecessor to Navigant Capital Advisors, LLC, Mr. Brady served as a General Manager and CFO for Doshi Diagnostic, one of the most profitable out-patient diagnostic centers in the U.S. and VP of Business Development for PrimeCare International. He also has worked in strategic planning and acquisitions for Caremark International, Inc. and as manager of Strategy and Planning, European Operations, for Baxter International, Inc. Mr. Brady received his Bachelor of Science in Finance from the Marriott School of the Brigham Young University and his MBA from Northwestern University's Kellogg Graduate School of Management. Mr. Brady is FINRA Series 7 and Series 63 licensed, and CIRA certified as an Insolvency Restructuring Advisor and certified in Distressed Business Valuation.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

NEIL F. LURIA
MANAGING DIRECTOR
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Neil Luria is a Managing Director with Navigant Capital Advisors and specializes in capital restructuring and operational support on behalf of the firm's clients. He has significant experience negotiating and structuring acquisitions, divestitures and structured settlements, overseeing asset liquidations, restructuring leases, real estate assets, hedge funds, loan origination and securitization. Mr. Luria joined Casas Benjamin & White, LLC a predecessor of Navigant Capital Advisors in 1999. While at Navigant Capital Advisors (and its predecessor), he has structured and overseen the successful disposition of over 250 business units, with a particular emphasis in healthcare services, real estate, consumer services, and distribution industries. In addition, Mr. Luria has overseen operating and capital restructurings in the capacity of Chief Restructuring Officer.

Mr. Luria has been heavily involved in the restructuring of commercial and residential real estate, including advising investment funds and real estate portfolios with respect to the restructuring of in excess of $15 BB of undeveloped land and $10 BB of commercial office properties. He is currently serving as the Chairman of the Official Committee of Unsecured Creditors of Neumann Homes, Inc., as well as Chairman of the Creditors Committees for subprime originators MILA, Inc. and Oak Street Mortgage. Mr. Luria also sits on the Official Committee of Unsecured Creditors of New Century Financial and People's Choice, two of the largest independent subprime originators. He is currently a member of the Board of Directors of Spectrum Diagnostic Imaging, LLC, one of the largest regional operators of diagnostic imaging centers and was formerly a member of the Board of Directors of Stampede Meats, Inc., one of the largest domestic meat processors. Mr. Luria is currently serving as Liquidating Trustee of Orthodontic Centers of America and Mortgage Lenders Network USA. He is presently one of the most active restructuring professionals in the subprime and Alt-A mortgage industry and is actively involved in the bankruptcies of numerous mortgage originators, on behalf of a large warehouse lender and repurchase claim creditors.

Before joining Navigant Capital Advisors (and its predecessor), Mr. Luria served as President of BMJ Medical Management, Inc., an operator of ambulatory surgery centers, imaging centers and physician practices, where he had previously served as Executive Vice President and General Counsel. While at BMJ, he oversaw the company's liquidation efforts that realized a 100% recovery to its Senior Secured Lenders. Prior to BMJ, he was engaged in the private practice of law at the firm of Jones Day Reavis & Pogue. Mr. Luria's practice involved the representation of venture capital and leverage buyout funds in connection with their portfolio investments, related add-on acquisitions and subsequent divestiture transactions. In addition, he was involved in numerous securities offerings ranging from global initial public offerings to private placements. He has also served as liquidating trustee in several high profile restructuring situations where he held fiduciary roles and was responsible for successfully winding down operations, disposing of liquid and non-liquid assets and over-sighting the litigation claims process.

Mr. Luria received his Juris Doctorate from the Boston University School of Law where he served on the Boston University Law Review and his Bachelor of Science in Economics from the Wharton School of the University of Pennsylvania. He also holds a CIRA certification as a Certified Insolvency & Restructuring Advisor.

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Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

MARK A. BRAZITIS
MANAGING DIRECTOR
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Mark Brazitis joined Navigant Consulting's Healthcare Practice with over 25 years of industry experience in progressively more responsible roles, including CEO of Lancaster Regional Health and CEO of Lancaster General Hospital. Mr. Brazitis specializes in organizational growth and development, turnarounds, business development and operations improvement. His background includes working with not-for-profit as well as for profit hospitals and health systems. Mr. Brazitis has provided consulting expertise to a variety of hospitals and health systems throughout the country to include OhioHealth, Sutter Health System, University of Maryland Medical System, Henry Ford Health System, Susquehanna Health System, Ministry Health System and Jewish Health System. Mr. Brazitis served as Interim CEO at Doctor's Hospital in Columbus, Ohio. He guided Doctor's through an operational turnaround and profitability. Mr. Brazitis has particular expertise in helping organizations address strategic, financial and operational challenges. Mr. Brazitis' professional experience includes: CEO, Lancaster Regional Health, Lancaster, PA, a two-hospital system with 416 beds, CEO, Lancaster General Hospital, Lancaster, PA, a 520-bed teaching facility with a $300 million budget.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

TOM HONAN
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Tom Honan, a Managing Director of Navigant Consulting, has more than 20 years of healthcare experience. He has served as an oversight executive, project director and team member on diverse consulting assignments and held interim management positions in community hospitals and major academic medical centers.

Mr. Honan has assisted Navigant Consulting on more than 80 engagements, serving as the oversight executive on projects for clients such as California Pacific Medical Center in California, Elliot Health System in New Hampshire, Lake Hospital System in Ohio, Morton Plant Mease in Florida, and the Unsecured Creditors Committee of Doctors Community Healthcare Corporation.

Additionally, Tom managed performance improvement plans for clients such as Virginia Commonwealth University Health System in Virginia, UMass Memorial Healthcare in Massachusetts, California Pacific Medical Center in California, St. Francis Hospital and Health Centers in Illinois, St. Joseph Hospital in Georgia, Hillcrest Healthcare System in Oklahoma and Westlake Hospital in Illinois. He has also directed and managed consolidation business plans for Morton Plant Health System and Mease Healthcare in Florida, Novant in North Carolina, California Pacific Medical Center and Davies Medical Center in California, Bon Secours and Christ Hospitals in New Jersey and Henry Ford Cottage Hospital and Bon Secours Hospital in Michigan. Tom has led and managed financial assessments of Beth Israel Hospital in New York and Mt. Sinai Health System in Illinois for the U.S. Department of Housing and Urban Development and prepared a governance and organizational structure study for SUNY Health Science Center at Brooklyn in New York.

Mr. Honan has also held interim management roles as COO and CFO at Detroit Medical Center, CFO at Allegheny Health, CFO at Baptist Health System, CFO at California Pacific Medical Center, and CFO at Brotman Medical Center in Los Angeles, California.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

EDWARD T. WENZKE
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Mr. Wenzke, a Managing Director in the Performance Improvement Practice at Navigant Consulting, has over 25 years of healthcare experience. He has served as an oversight executive, project director and team member on diverse consulting assignments and has held interim management positions in community hospitals and tertiary medical centers.

Prior to his consulting work, Mr. Wenzke served in positions of increasing managerial responsibility, which culminated in his tenure as president and CEO of a hospital system with a combined annual operating budget of $300 million.

For Navigant Consulting, Mr. Wenzke has directed or overseen over 40 engagements involving corporate services, labor effectiveness, performance improvement plan development, physician services, strategic alignment and academic funds flow. He has particular expertise in helping organizations address strategic, financial and operational challenges. His clients include Sentara Healthcare, Virginia, Catholic Health Partners, Ohio, Fairview Health System, Minnesota, Baptist Health Care Corporation, Tennessee, UAB Health System, Alabama, Piedmont Healthcare, Georgia, Catskill Regional Medical Center, New York, University of Arkansas for Medical Sciences, Arkansas and Maimonides Medical Center, New York.

Additionally, Mr. Wenzke has held interim management roles as COO at St. Vincent Catholic Medical Center, CEO at Walker Baptist Hospital , COO for St. Mary's of Michigan, CEO Provena Mercy Hospital and CRO at Catskills Regional Medical Center.

Mr. Wenzke holds a Bachelors Degree in Business Administration from Ohio State and a Masters in Healthcare Administration from Xavier University.

Healthcare Solutions Leadership Team

Key Member Biographies (cont.)

ROGER E. KAISER, MD
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813.277.1900

Dr. Roger Kaiser, a Managing Director of Navigant Consulting's healthcare practice, has an impressive clinical, medical education, and management background spanning almost 25 years serving integrated healthcare systems, academic medical centers, ambulatory surgical centers, public, not-for-profit and for-profit organizations. Dr. Kaiser is recognized for his exceptional skills in turnaround and implementation management, strategic positioning, physician collaboration/integration, quality and performance improvement, fiscal management and service growth. His strengths include communications, strategic vision, medical staff development and motivation, and physician support. Dr. Kaiser has participated in a number of engagements since joining Navigant Consulting, in a wide range of interim management and consulting roles including serving in an advisory capacity during the performance improvement project at Martin Luther King Drew Medical Center in Los Angeles, CA. During this role, Dr. Kaiser worked with the Director, Los Angeles County Department Health Services and King Drew's Chief Executive Officer and Chief Medical Officer on issues related to quality and clinical performance improvement, and medical staff redesign in preparation for CMS and JCAHO accreditation. Dr. Kaiser also was a member of the interim management team that led Passiac Beth Israel Hospital (Passiac, NJ) through a successful restructuring and subsequent sale.

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EXHIBIT Q7-4

BIOGRAPHIES AND QUALIFICATIONS OF PRINCIPLE VALUATION

PATRICK J. SIMERS
EXECUTIVE VICE PRESIDENT

EXPERIENCE

Mr. Simers has extensive experience in serving the valuation needs of the health-care industry. He has valued all tangible and intangible assets associated with health-care enterprises, including the capital stock of majority and minority share holdings; medical specialty and physician joint ventures; fee simple, leased fee, and leasehold interests in real estate for hospital systems, stand-alone hospital campuses, and medical office buildings; major and minor movable equipment; certificates of need; contractual agreements; and preferred provider arrangements.

Specific healthcare enterprises appraised include acute care hospital facilities, LTACH hospitals, psychiatric hospitals, rehab hospital facilities, single physician practices, multi-specialty practices, cath labs, diagnostic centers, cardiac care practices, home health agencies, nursing homes, assisted living facilities, and medical office buildings.

Mr. Simers has performed fair market value studies for purchase, sale, or financing; merger and acquisition consulting; negotiation of purchase price; fairness opinions; purchase price allocations; financial reporting; SEC reporting; Medicare regulatory requirements; Safe Harbor requirements; and 501(c)(3) private placement offerings.

PROFESSIONAL HISTORY

Mr. Simers began his appraisal career with Valuation Counselors in 1982 and held various consulting, business development, and management roles, including four years as president of Valuation Counselors, leading up to its merger with CBIZ Inc. Most recently, Mr. Simers has served as the National Director for Healthcare services for American Appraisal Associates where he spear-headed the development of healthcare services for this international appraisal firm.

Patrick J. Simers is Executive Vice President for Principle Valuation. He is responsible for the development and overall business plan for Principle's consulting and appraisal services to for-profit, nonprofit, and public health-care providers. Mr. Simers is located in Principle Valuation's Atlanta office.

PROFESSIONAL AFFILIATIONS

- American Health Lawyers Association
- Healthcare Financial Management Association

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Northern Illinois University with a Bachelor of Science in Finance and Economics
- Graduate of Moraine Valley College with an Associate in Arts in Business Administration
- Certified General Real Estate Appraiser in Georgia
- Certified General Real Estate Appraiser in Florida (#RZ3581)

SALLY M. DOMIJAN

EXPERIENCE

Ms. Domijan has experience in the valuation of business enterprises, majority and minority capital stock interests in privately held companies, intangible assets, preferred stock, restricted stock, and options. In addition she has completed valuations for acquisitions, corporate planning, financial accounting, employee stock ownership plans, fairness opinions, divorce litigation, possible sale, and estate planning purposes.

She has experience valuing a variety of business assets including: trade names, assembled workforce, computer software, medical records, Certificates of Need, noncompete agreements, and specific technologies. She has specialized experience in performing healthcare valuations, including those for hospital systems, ambulatory surgical centers, diagnostic imaging centers, physician practices, clinical labs, healthcare information systems, inpatient and outpatient rehabilitation centers, dialysis centers, home health agencies, medical device companies, HMOs/PPOs, and medical supply companies.

PROFESSIONAL HISTORY

Ms. Domijan is in the Financial Valuation department for Principle Valuation. She has over 20 years in the valuation industry, formerly as a Director of Financial Valuations with American Appraisal, as Director of Financial Valuations with L.T. Annum Appraisal Services, Inc., and a Manager at CBIZ Valuation Group (formerly Valuation Counselors). Prior to that she was a financial analyst in the savings and loan industry.

PROFESSIONAL AFFILIATIONS

- CFA Institute
- CFA Society, Chicago

EDUCATION LICENSES, AND DESIGNATIONS

- University of Illinois at Chicago, Master of Business Administration with a specialization in finance and economics
- Miami University, Oxford, Ohio, Bachelor of Science with a concentration in accounting and finance
- Chartered Financial Analyst

TESTIMONY

- Ms. Domijan has presented testimony as an expert witness in Divorce Court in Cook County. Ms. Domijan has been deposed on valuation matters.

BRIAN O. SPILLERS

EXPERIENCE

Mr. Spillers has been engaged in the advisory, consulting and valuation profession since 1995. His experience has focused on the healthcare industry, and he has performed consulting and valuation assignments involving a variety of assets, including senior living properties, healthcare facilities, and professional office properties. These assignments have included project development, financing, acquisition advisory and integration, divestiture, work-out and turn-around studies for financially distressed properties, data gathering tools, industry research, regulatory approvals and reimbursement purposes.

His experience includes the estimation of market, fee-simple, investment, leasehold and leased fee values covering various assets, focused primarily on healthcare enterprises, and including acute and rehabilitation hospitals, nursing facilities, psychiatric facilities, retirement communities and assisted-living residences.

In the healthcare and senior housing industry, Mr. Spillers has developed detailed market analysis to examine the potential market feasibility of proposed projects. These market assessments include the definition of a primary market area, detailed service analysis, detailed analysis of demographic characteristics and the estimation of demand in the defined primary market area, and have been utilized in connection with proposed healthcare projects as well as projects encountering difficulty with absorption for various financial institutions and healthcare providers.

PROFESSIONAL HISTORY

Mr. Spillers has worked with Principle Valuation, LLC since 2007. Previously, he has been employed by several national healthcare consulting firms. He also served as a contract negotiator with a New York based international financial services firm.

EDUCATION LICENSES, AND DESIGNATIONS

- A graduate of Saint Joseph's University, with a bachelor of science degree in Finance
- New Jersey Certified General Appraiser's license (42RG00220200)

Mr. Spillers has also attended numerous national and regional finance, regulatory and healthcare conventions.

EXHIBIT Q7-5

FAIRNESS EVALUATION PREPARED PRINCIPLE VLAUATION, LLC AND SUPPORTING SCHEDULES

Principle Valuation, LLC
PEOPLE AND VALUES YOU CAN TRUST

October 20, 2015

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Attention: Ms. Darlene Stromstad, FACHE

Re: Fairness Opinion for Conversion of Greater Waterbury Health Network, Inc.

Ladies and Gentlemen:

Pursuant to the Asset Purchase Agreement (Draft dated August 26, 2015), Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will contribute substantially all of their operating assets ("Assets") to a Prospect Affiliate ("Purchaser"), with Prospect Medical Holdings, Inc. ("Prospect Medical", "PMH") as indirect owner.

Pursuant to the proposed Transaction the Board of GWHN has asked Principle Valuation to provide the Board a fairness evaluation of the Transaction to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 19a-486 et seq. ("Conversion Statute"). The date of our analysis is September 1, 2015 giving consideration to historical data available as of June 30, 2015 and subsequent financial data provided to us by the GWHN and their financial consultants.

KEY ELEMENTS OF THE TRANSACTION

We have included the draft of the Asset Purchase Agreement provided to us in the Addenda of this report. Key elements of the Transaction include the following:

- Prospect Affiliate will purchase GWHN's Assets (inclusive of approximately $6,800,000 of net working capital assets) for $45,000,000;
- Prospect Affiliate will assume $14,970,635 of Liabilities from GWHN which will be credited from the cash payments to GWHN;
- Prospect Affiliate will assume the actuarial shortfall on the nurses pension;
- Prospect Affiliate will make a commitment to expend $55,000,000 in capital or other approved commitments for the development and improvement of the hospital, ambulatory or other health care services in the greater Waterbury, CT community over a seven year time frame.

- Seller has the right, if the Buyer sells the Hospital's Business for cash within the first three years of the transaction, to receive 20% of the difference between the cash purchase price paid and the Net Hospital Value.

The Asset Purchase Agreement includes additional understandings and terms not directly related to the financial aspects of the transaction. While we recognize that all parties to the Transaction anticipate that the transaction will enhance the quality and access to healthcare in the community, these factors are difficult to quantify economically and have only been incidentally factored into our conclusions.

SCOPE

In determining whether the consideration is fair from a financial point of view, we have compared the financial rights and responsibilities that currently are held by GWHN with the proposed sales terms. In arriving at the opinion set forth below, we have among other things:

- Visited the Waterbury Hospital Site to describe and assess the overall condition of the physical assets and improvements (Inspections occurred in November 2011 and July 2014). We assumed similar conditions at the facility as of the current analysis;
- Reviewed and relied upon certain information contained in the Confidential Information Memorandum ("CIM") prepared by Cain Brothers in September 2012, and relied upon subsequent representations by Cain Brothers as to their subsequent efforts that were used to solicit other offers of interest for GWHN;
- Been provided and reviewed certain available business and financial information relating to the GWHN that was provided by GWHN's management team and produced subsequent to the CIM, including audited financial statements for the fiscal years ended September 30, 2011 through September 30, 2014 and internally prepared financial statements for the nine months ended June 30, 2015;
- Been provided and relied upon income statement estimates for the fiscal years 2016 through 2018 prepared by GWHN showing GWHN as a Stand-Alone organization if the transaction does not occur;
- Reviewed the prior offers for the subject property over the past several years;
- Reviewed the initial offer outlines by Prospect Affiliate;
- Considered the criteria set forth in the Conversion Statute;
- Interviewed members of GWHN's management;
- Reviewed the Draft Asset Purchase Agreement by and among Greater Waterbury Health Network, Inc. and Buyer dated August 26, 2015;
- Reviewed minutes of the Board of Directors of GWHN for the period February 14, 2013 through August 13, 2015, including the 2014 and 2015 annual meeting minutes; the Waterbury Hospital Joint Task Force meeting minutes of October 17, 2012, July 8, 2013, March 27, 2014, June 26, 2014, August 18, 2014, December

18, 2014, February 12, 2015, March 13, 2015, April 23, 2015, September 10, 2015; and the special board meeting minutes of October 18, 2012, October 25, 2012, April 16, 2015, and April 29, 2015;

- Reviewed the minutes of the Finance Committee for the period May 6, 2014, June 10, 2014, and monthly from the period January 6, 2015 through August 4, 2015;
- Reviewed the Company information and financial information concerning Prospect Medical;
- Reviewed such other financial studies and analysis and took into account such other matters as we deemed necessary, including our assessment of general economic market and monetary conditions.
- Reviewed the historical market prices, trading activity and valuation multiples of certain publicly traded companies that we deemed to be relevant and used them as benchmarks to estimate relative criteria in our analysis; and
- Compared the proposed financial terms of the proposed purchase with certain other transactions that we deemed relevant.

In preparing our opinion, we have assumed and relied on the accuracy and completeness of all information supplied or otherwise made available to us, discussed with or reviewed by or for us, or publically available, and we have not assumed any responsibility for independently verifying such information. Nor have we evaluated the solvency or fair value of GWHN under any state or federal laws relating to bankruptcy, insolvency, or similar matters. The Asset Purchase Agreement speaks to specific remedies and obligations based upon future potential events occurring. In deriving our opinion, to the extent reasonably possible, we have considered the financial impact of these events and their overall impact on the consideration offered.

We have made a physical visit to the Waterbury Hospital and have assessed the contributory value of the depreciated replacement cost of the fixed assets currently present at the site. The inspections occurred in November 2011 and July 2014. We assumed similar conditions at the facility as of the current analysis. With respect to the financial forecast provided to or discussed with us by representatives of GWHN, we have assumed that they have been reasonably prepared and reflect the best currently available estimates and judgment of GWHN as to the expected future financial performance of the Hospital. We have also assumed that the final form of the Asset Purchase Agreement presented to us will be substantially similar to the draft reviewed by us dated August 26, 2015.

We understand the parties have agreed that the Children's Center of Greater Waterbury Health Network, Inc. and Healthcare Alliance Insurance Company, Ltd. are not included in the transaction and have incorporated that in our analysis.

Our opinion is necessarily based upon market, economic and other conditions as they exist and can be evaluated, and on the information made available to us as of the date hereof. We have assumed that there are no undisclosed or unexpected conditions that would affect the value of GWHN's assets or the financial condition or operations of GWHN or the expected future financial performance of GWHN. We have assumed that that in the course of obtaining the necessary

regulatory or other consents or approvals (contractual or otherwise) for the Transaction, no restrictions, including any amendment or modifications, will be imposed that will have a material adverse effect on the transaction.

In connection with the preparation of this opinion, we have not been authorized by GWHN to solicit, nor have we solicited, third-party indications of interest for the acquisition of GWHN's interest.

We are not acting as a financial advisor to any party in this arrangement. Our fees for this engagement are not at all dependent upon the opinion rendered. We have performed work for GWHN in the past in a similar role associated with a failed transaction. GWHN has agreed to indemnify us for certain liabilities arising out of our engagement.

USE

These valuation-consulting services are intended to assist the Board in meeting its fiduciary duties and obligations under the Conversion Statute. Our work is not intended to establish specific pricing recommendations; rather, it is designed to provide the Board with relevant data that will allow it to make an informed decision. Our opinion does not constitute a recommendation regarding the proposed transaction, or any matter related thereto.

We understand that the report may be requested by Connecticut's Attorney General in his overall assessment of the transaction and that we may be required to respond to some of his inquiries about our overall analysis.

CONCLUSIONS

We understand that under the Conversion Statute, the Attorney General shall deny an application as not in the public interest if the Attorney General determines that one or more of the following conditions exist and, as requested by GWHN, we respond to these criteria below to the best of our knowledge and expertise:

(1) The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities;

Please note that we are not admitted to practice law in Connecticut and are not qualified to make this opinion. GWHN and its Transaction attorney have indicated to us that there is no absolute prohibition of the Transaction by Connecticut statutory or common law governing nonprofit entities, trusts or charities, other than that the requirements of the Conversion Statute must be satisfied.

(2) the nonprofit hospital failed to exercise due diligence in (A) deciding to transfer, (B) selecting the purchaser, (C) obtaining a fairness evaluation from an independent person expert in such agreements, or (D) negotiating the terms and conditions of the transfer;

Having reviewed the minutes of the Board and the task force and speaking with GWHN's management, counsel and financial advisors, we find that the Board has exercised due diligence

in deciding to transfer, selecting Prospect Affiliate as the purchaser, and negotiating the terms and conditions of the transfer.

This firm responded to an RFP issued by GWHN, provided its qualifications and was chosen after review of those qualifications and an interview. Principle Valuation, Inc. is independent; it is being paid a flat non-contingent fee for its work on the Transaction.

(3) the nonprofit hospital failed to disclose any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of the hospital, the purchaser or any other party to the transaction;

We are aware that GWHN circulated and received responses to queries of its board members, officers, key employees and experts as well as those of the purchaser with respect to conflicts of interest. While we have not conducted any review in this regard, we are not aware of any undisclosed conflict of interest.

(4) the nonprofit hospital will not receive fair market value for its assets, which, for purposes of this subsection, means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market;

On the basis of and subject to the foregoing, we are of the opinion that, as of September 1, 2015, the Consideration set forth in the Transaction is fair from a financial point of view to the GWHN.

(5) the fair market value of the assets has been manipulated by any person in a manner that causes the value of the assets to decrease;

As noted previously, we have performed reviews of GWHN's financials and assets and find no indication that the fair market value of its assets has been manipulated by any person in a manner that causes the value of the assets to decrease.

(6) the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk;

The Transaction does not encumber GWHN with any financing for the completion of this transaction; consequently, there is no financing of the proposed transaction that would place the nonprofit hospital's assets at an unreasonable risk upon completion of the Transaction.

(7) any management contract contemplated under the transaction is not for reasonable fair value;

We have not reviewed any potential management contracts contemplated under the transaction.

(8) a sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the superior court for the judicial district where the nonprofit hospital is located who are not affiliated through

corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor;

Based on the materials and interviews referenced in this letter and our review of the proposed plans for a post conversion foundation, (a) the fair market value of GWHN's assets will be received and (b) the existing Waterbury Hospital will continue to operate for the support and promotion of health care generally in the hospital's service area. GWHN and its Transaction Attorney have indicated to us that the restricted assets will be used for purposes consistent with the intent of their donors. Principle Valuation has conducted no investigation into the source, limitations, or value of the restricted use assets.

(9) the nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately.

Principle Valuation is not acting, in any fashion, as an agent of the Transaction; and therefore has no opinion as to whether or not all data and information sufficient to evaluate the proposed transaction has been provided to the Attorney General. GWHN advises us that the Attorney General has not concluded its request for information with respect to the Transaction.

Respectfully submitted,

PRINCIPLE VALUATION, LLC

Principle Valuation LLC

PV15.1672

Principle Valuation, LLC

People and Values you can Trust

Greater Waterbury Health Network – Qualitative & Quantitative Considerations

Fairness Opinion

September 25, 2015

Introduction And Background

Pursuant to the Asset Purchase Agreement, (draft dated August 26, 2015), Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will sell substantially all of their operating assets ("Assets") to a Prospect Affiliate ("Purchaser"), with Prospect Medical Holdings, Inc. ("Prospect Medical", "PMH") as indirect owner.

Pursuant to the proposed Transaction the Board of GWHN has asked Principle Valuation to provide the Board a fairness evaluation of the Transaction to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 19a-486 et seq. ("Conversion Statute").

The Fairness Opinion will be provided in a separate letter. This document is presented to the Board and Financial Advisors of GWHN as a supplemental document to highlight the overall process and primary assumptions utilized in arriving at our final conclusion. This document is not being specifically prepared to present to the Attorney General ("AG"); it is a high level document that should be reviewed by the Board and its Financial Advisors for accuracy with respect to the historical information contained herein and general agreement as to underlying operating assumptions utilized. Similar schedules or explanations may be required by the AG upon his review of the final Fairness Opinion and the Transaction in general.

In the proposed transaction, Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will sell substantially all of its assets to an Affiliate of Prospect Medical.

Introduction And Background

GWHN has been seeking a capital partner since 2011. Its efforts have been quite exhaustive including consideration of a joint venture Agreement with LHP solely; a successive joint venture arrangement with LHP and St. Mary's which would have developed a new state-of-the-art facility and a single provider for the market; and then a joint venture arrangement with Vanguard/Tenet in 2013. Despite strong efforts to complete each of these transactions; for a variety of different reasons, the partners decided to withdraw from the transactions. During this same period, the economic challenges at the facility have increased with each successive year incurring decreased earnings, staff reductions, and necessary capital improvements were shelved. In order to insure that it could fulfill its healthcare mission and future, the Board has continued to seek a capital partner with the assistance of Cain Brothers. Through this process, including the ventures mentioned above, there have been more than 20 potential purchasers canvassed to invest in the operation since 2011. In April, 2015, Prospect Medical Holdings Inc. made an offer substantially similar to the Vanguard/Tenet offer and the Board has asked Principle Valuation to assess its financial fairness.

Prospect Medical Holdings is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates thirteen 13 acute care and behavioral hospitals located in Rhode Island, Texas and California. Overall, PMH operates 2,258 licensed beds. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 260,000 patients in Southern California, South Central Texas and Rhode Island through a network of approximately 8,900 physicians.

Outline of Proposed Transaction

In the proposed transaction, Greater Waterbury Health Network, Inc. and its affiliates ("GWHN") will sell substantially all of their assets to a Prospect Affiliate.

Prospect Affiliate is indirectly owned by Prospect Medical Holdings, Inc. ("Prospect Medical"). Prospect Medical is a provider of healthcare services through its hospitals, clinics, and physician networks. It currently owns 13 hospitals in three states including Southern California, South Central Texas, and Rhode Island.

Key elements of the transaction are as follows:

- Prospect Affiliate will purchase GWHN's Assets (inclusive of approximately $6,800,000 of net working capital assets) for $45,000,000;
- Prospect Affiliate will assume $14,970,635 of Liabilities from GWHN which will be credited from the cash payments to GWHN;
- Prospect Affiliate will assume the actuarial shortfall on the nurses pension;
- Prospect Affiliate will make a commitment to expend $55,000,000 in capital or other approved commitments for the development and improvement of the hospital, ambulatory or other health cares services in the greater Waterbury, CT community over a seven year time frame;
- Seller has the right, if the Buyer sells the Hospital's Business for cash within the first three years of the transaction, to receive 20% of the difference between the cash purchase price paid and the Net Hospital Value.

Assets Anticipated to Transfer

GWHN will transfer substantially all of its operating assets or equity interests in its affiliates to Prospect Affiliate. This would include all the tangible and intangible assets currently utilized in the hospital's operations. Tangible assets would include a net working capital balance of approximately $6,800,000, inventories, prepaid insurance, other prepaid expenses, the real estate and equipment. Intangible assets would included all of the ownership interests held in the affiliate companies (other than the Children's Center of Greater Waterbury Health Network, Inc. and Healthcare Alliance Insurance Company, Ltd.), the operating licenses, contracts, tradenames, trademark, web sites, etc. All assets will be transferred essentially free and clear of any encumbrances.

The legacy hospital entity will maintain Cash and Cash Equivalents, Short-Term Investments, Assets Due From Affiliates, Noncurrent Assets Who Use is Limited and Funds Held in Trust by Others. It will also maintain a portion of Net Accounts Receivable, Accounts Receivable Other Prepaid Insurance and Other Expenses, and Net PP&E. The legacy hospital entity will remain responsible for payments Due to Third Party Payors, Long-Term Debt, Workers Compensation, Malpractice, and Other Long-term Liabilities. It will maintain a portion of Accounts Payable. These accounts are detailed on the following schedules.

As contemplated, $19,338,842 of cash will be delivered to GWHN at closing. The legacy hospital entity will be responsible for addressing the liabilities at and after closing.

The Net Proceeds Calculation prepared by Management is presented on the following schedules.

Net Proceeds Calculation Prepared By Management

	Balance Sheet as of 6/30/2015 (Ownership Adjusted)	Pro Forma	
		Retained by Surviving Entity	Purchased/ Assumed by Prospect
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 19,594,297	$ 19,594,297	$ -
Short-term Investments	$ 1,546,952	$ 1,546,952	$ -
Net Accounts Receivable	$ 35,489,960	$ 128,166	$ 35,361,793
Accts Receivable - Other	$ 4,141,299	$ 3,753,101	$ 388,198
Inventories	$ 4,004,633	$ -	$ 4,004,633
Prepaid Insurance and Other Expenses	$ 3,867,336	$ 1,415,103	$ 2,452,234
Due From Affiliates	$ 684,423	$ 684,423	$ -
Total Current Assets	$ 69,328,900	$ 27,122,042	$ 42,206,858
Noncurrent Assets Who Use Is Limited:			
CHEFA Bond Issue Cost	$ 304,391	$ 304,391	$ -
Investments	$ 27,283,068	$ 27,283,068	$ -
Board Designated Funds	$ 3,335,566	$ 3,335,566	$ -
Loans and Other Receivables	$ 207,606	$ 207,606	$ -
Funds Held in Trust by Others	$ 45,948,228	$ 45,948,228	$ -
Goodwill	$ 1,813,567	$ -	$ 1,813,567
Net PP&E	$ 32,549,045	$ 2,019,190	$ 30,529,855
Total Assets	**$ 180,770,372**	**$ 106,220,092**	**$ 74,550,280**

Net Proceeds Calculation Prepared By Management

	Balance Sheet as of 6/30/2015 (Ownership Adjusted)	Pro Forma	
		Retained by Surviving Entity	Purchased/ Assumed by Prospect
Liabilities			
Current Liabilities			
Accounts Payable and Accrued Expenses	$ (22,804,373.65)	$ (2,851,357)	$ (19,953,016.23)
Current Portion of Accrued Pension Liablility	$ (3,388,000)	$ -	$ (3,388,000)
Current Portion of Long Term Debt	$ (950,926)	$ (570,943)	$ (379,982)
Due to Third-Party Payors	$ (7,912,485)	$ (7,912,485)	$ -
Total Current Liabilities	$ (35,055,784)	$ (11,334,785)	$ (23,720,999)
Long-Term Debt	$ (24,890,080)	$ (24,918,725)	$ 28,645
Other Long-Term Liabilities:			
Workers Compensation	$ (12,417,149)	$ (12,417,149)	$ -
Pension	$ (8,429,374)	$ -	$ (8,429,374)
Malpractice	$ (1,962,990)	$ (1,962,990)	$ -
Asbestos Abatement	$ (2,801,923)	$ -	$ (2,801,923)
Other Long-Term Liabilities	$ (2,082,328)	$ (2,082,328)	$ -
Total Other Liabilities	$ (52,583,844)	$ (41,381,191)	$ (11,202,653)
Total Liabilities	**$ (87,639,628)**	**$ (52,715,977)**	**$ (34,923,651)**
Net Assets	$ 93,130,744	$ 53,504,115	$ 39,626,629
Net Balance Sheet Items	**$ 180,770,372**	**$ 106,220,092**	**$ 74,550,280**

Net Proceeds Calculation Prepared By Management

Foundation Asset Adjustments

Deal Terms		
Enterprise Value	$	45,000,000
Balance Sheet Liabilities Assumed by Prospect	$	(14,970,635)
Nurses Pension (Asset Shortfall)	$	(15,900,000)
Prospect Proposed Pension Rate Change	$	(7,000,000)
Additional Capital Leases Assumed by Prospect	$	(3,120,018)
Working Capital Adjustment	$	15,329,495
Cash Proceeds Received at Closing	$	19,338,842
Foundation Cash Needs at Closing		
Malpractice Tail Insurance and LPT Expense	$	(7,722,530)
Estimated Transaction Costs	$	(2,650,000)
Contingencies	$	(1,000,000)
Total Cash Needs at Closing	$	(11,372,530)
Net Cash Proceeds to Foundation	**$**	**7,966,312**
Net Asset Calculation		
Net Foundation Assets Before Adjustments	$	53,504,115
Write-off of Other Assets	$	(1,415,103)
Net Cash Proceeds to Foundation	$	7,966,312
Net Assets at Closing	**$**	**60,055,325**

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion

In deriving our "Fairness Opinion", we considered the value of the assets transferred against the value of the benefits to be received from a financial point of view. While we recognize that all parties to the Transaction anticipate that the transaction will enhance the quality and access to healthcare in the community, these factors are difficult to quantify economically and have only been incidentally factored into our conclusions.

In assessing the value of the assets transferred we considered the three traditional valuation methodologies: the Cost Approach, Market Approach, and Income Approach.

In assessing the value of the benefits received by the Transaction, we considered the cash benefits received to the post conversion foundation and the value of the assumed liabilities transferred to Prospect Medical.

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion - Continued

In deriving our "Fairness Opinion" we have among other things:

- Visited the Waterbury Hospital site to describe and assess the overall condition of the physical assets and improvements. (Inspections occurred in November 2011 and July 2014). We assumed similar conditions at the facility as of the current analysis;
- Reviewed and relied upon certain information contained in the Confidential Information Memorandum ("CIM") prepared by Cain Brothers in September 2012, and relied upon subsequent representations by Cain Brothers as to their subsequent efforts that were used to solicit other offers of interest for GWHN;
- Been provided and reviewed certain available business and financial information relating to GWHN that was provided by GWHN's management team and produced subsequent to the CIM, including audited financial statements for the fiscal years ended September 30, 2011 through September 30, 2014 and internally prepared financial statements for the nine months ended June 30, 2015;
- Been provided with and relied upon income statement estimates for the fiscal years 2016 through 2018 prepared by GWHN showing GWHN as a Stand-Alone organization if the transaction does not occur;
- Reviewed prior offers for the subject property over the past several years;
- Reviewed the initial offer outlines by Prospect Affiliate;
- Considered the criteria set forth in the Conversion Statute;

(Continued)

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion - Continued

In deriving our "Fairness Opinion" we have among other things (continued):

- Interviewed members of GWHN's management;
- Reviewed the Draft Asset Purchase Agreement by and among Greater Waterbury Health Network, Inc. and Buyer dated August 26, 2015;
- Reviewed minutes of the Board of Directors of GWHN for the period February 14, 2013 through August 13, 2015, including the 2014 and 2015 annual meeting minutes; the Waterbury Hospital Joint Task Force meeting minutes of October 17, 2012, July 8, 2013, March 27, 2014, June 26, 2014, August 18, 2014, December 18, 2014, February 12, 2015, March 13, 2015, April 23, 2015, September 10, 2015; and the special board meeting minutes of October 18, 2012, October 25, 2012, April 16, 2015, and April 29, 2015;
- Reviewed minutes of the Finance Committee for the period May 6, 2014, June 10, 2014, and monthly from the period January 6, 2015 through August 4, 2015;
- Reviewed the Company information and financial information concerning Prospect Medical;
- Reviewed such other financial studies and analysis and took into account such other matters as we deemed necessary, including our assessment of general economic market and monetary conditions;
- Reviewed the historical market prices, trading activity and valuation multiples of certain publicly traded companies that we deemed to be relevant and used them as benchmarks to estimate relative criteria in our analysis.

Critical Facts and Assumptions

The following critical facts and assumptions among other factors were considered in deriving our overall estimates:

- GWHN is one of two primary healthcare providers in the Greater Waterbury market area;
- In the absence of this transaction, GWHN will face increased competition from St. Mary's and other nearby hospitals and systems;
- Waterbury's physical plant is approaching the end of its economic life and needs renovation within the next five to seven year period. Based upon a physical inspection, discussions with management, and the actual age and condition of the property, we have assigned a remaining economic life for the Waterbury Campus of five years in the absence of an alternative capital resource partner;
- It is anticipated by management that GWHN's earnings will continue to deteriorate due to the increased competition, lower volumes and costs associated with its physical plant to the point that the overall business operations will generate marginal to negative cash flows;
- In the absence of this Transaction and in consideration of the factors stated above, the overall economic viability of the organization and its ability to continue its healthcare mission in the foreseeable future is limited.

Valuation of Assets Contributed - Overview

In deriving the value of the assets to be contributed to Prospect Medical, we considered the three principal methods of valuation: the Cost Approach (Adjusted Book Value Approach), the Market Approach, and the Income Approach. Each Approach as applied to GWHN is briefly explained below:

- In the Cost Approach, the tangible assets of GWHN were valued by deriving a depreciated replacement cost for the tangible assets in use. The land was valued at its current value assuming current market data. The Net Working Capital was valued based upon the stated value on the Balance Sheets provided. A Summary of this Approach is shown on Schedule 1A.

- In the Income Approach to Value, we considered the value of GWHN utilizing a Discounted Cash Flow approach based upon market based cost of capital considerations and the anticipated limited earning capacity of GWHN in a "Stand-Still" strategic choice. This analysis is shown in Schedule 1B.

- We considered two Market Based approaches in estimating the value of the subject; Guideline Company Approach and Guideline Transaction Approaches to value. These approaches are shown on Schedules 1C and 1D, respectively.

After considering the strengths and weakness of each approach, we derived an overall weighted value for the assets contributed.

Schedule 1A – Cost Approach Summary

WATERBURY HOSPITAL - SCHEDULE 1A

VALUATION SUMMARY AS OF JUNE 2015 WITH ECONOMIC DEPRECIATION

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

Tangible Asset Value Summary

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

Schedule 1B – DCF Stand Still

Discounted Cash Flow GWHN "Stand-Still" - Schedule 1B									
		Fiscal Year Ended September 30,		Trailing Twelve Months	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
		FY 2013	FY 2014	6/30/2015	Projected	Projected	Projected	Projected	Projected
NET PATIENT REVENUE									
Net Patient Service Revenues		$ 259,397,257	$ 253,394,006	$ 247,217,460	$ 255,217,792	$ 258,488,857	$ 260,749,204	$ 267,267,934	$ 273,949,632
Provision for Bad Debts		(11,368,671)	(4,454,817)	(3,206,224)	(3,948,763)	(4,000,648)	(4,030,001)	(4,130,751)	(4,234,020)
Total Net Patient Service Rev Less Bad Debts		248,028,586	248,939,189	244,011,236	251,269,029	254,488,209	256,719,202	263,137,183	269,715,612
Other Operating Revenue		4,725,959	4,483,138	5,762,534	14,643,067	14,825,462	14,878,373	15,250,332	15,631,591
Revenue from Operations		$ 252,754,545	$ 253,422,327	$ 249,773,770	$ 265,912,096	$ 269,313,671	$ 271,597,575	$ 278,387,515	$ 285,347,203
Growth			0.3%		6.5%	1.3%	0.8%	2.5%	2.5%
OPERATING EXPENSES									
Salaries, Wages, and Benefits	v	$ 152,117,220	$ 151,760,190	$ 157,123,840	$ 156,423,303	$ 159,589,217	$ 162,790,793	$ 164,248,634	$ 168,354,850
Supplies, Utilities, and Other	f	101,697,631	107,222,243	103,231,324	108,173,646	108,245,192	108,782,377	111,501,936	114,289,485
Subtotal		253,814,851	258,982,433	260,355,164	264,596,949	267,834,410	271,573,170	275,750,570	282,644,334
Depreciation/Amortization	f	8,996,581	7,991,436	7,393,894	6,849,701	6,838,400	6,830,365	7,001,124	7,176,152
Interest Expense	f	1,125,827	1,476,326	1,435,535	1,353,599	1,353,349	1,353,349	1,387,183	1,421,862
Total Operating Expense		$ 263,937,259	$ 268,450,195	$ 269,184,593	$ 272,800,249	$ 276,026,159	$ 279,756,884	$ 284,138,877	$ 291,242,349
Gain/(Loss) from Operations		$ (11,182,714)	$ (15,027,868)	$ (19,410,823)	$ (6,888,153)	$ (6,712,488)	$ (8,159,309)	$ (5,751,362)	$ (5,895,146)
Total Non-Operating Income(2)		7,988,488	8,497,993	6,634,714	8,407,685	8,433,432	8,460,337	8,671,846	8,888,642
Excess of revenue over expenses		$ (3,194,226)	$ (6,529,875)	$ (12,776,109)	$ 1,519,532	$ 1,720,944	$ 301,029	$ 2,920,484	$ 2,993,496
EBITDA (excluded non-operating income)		$ (1,060,306)	$ (5,560,106)	$ (10,581,394)	$ 1,315,147	$ 1,479,262	$ 24,405	$ 2,636,945	$ 2,702,868
EBITDA Margin		*-0.4%*	*-2.2%*	*-4.2%*	*0.5%*	*0.5%*	*0.0%*	*0.9%*	*0.9%*
EBIT		$ (10,056,887)	$ (13,551,542)	$ (17,975,288)	$ (5,534,554)	$ (5,359,138)	$ (6,805,959)	$ (4,364,179)	$ (4,473,284)
Note:									
(1) Revenue excludes EHRIT Meaningful Use revenue of the following:		$ 2,277,750	$ 1,507,510						
(2) Net Assets Released from Restrictions is shown in Total Non-Operating Income									

Schedule 1B – DCF Stand Still (Continued)

Discounted Cash Flow GWHN "Stand-Still" - Schedule 1B					
Discount Rate	11.00%				
Effective Corporate Tax Rate in U.S, CT	39.88%				
Normal Debt Free Net Working Capital as % of Revenues	12.00%				
	FY 2016 Projected	FY 2017 Projected	FY 2018 Projected	FY 2019 Projected	FY 2020 Projected
NET INCOME FOR DISCOUNTING (EBIT)	$ (5,534,554)	$ (5,359,138)	$ (6,805,959)	$ (4,364,179)	$ (4,473,284)
ESTIMATED INCOME TAXES	(2,207,180)	(2,137,224)	(2,714,217)	(1,740,435)	(1,783,946)
NET INCOME	**$ (3,327,374)**	**$ (3,221,914)**	**$ (4,091,743)**	**$ (2,623,744)**	**$ (2,689,338)**
Less Incremental Working Capital	$ (1,498,772)	$ (408,189)	$ (274,068)	$ (814,793)	$ (835,163)
Less Capital Expenditures	(7,857,143)	(7,857,143)	(7,857,143)	(7,857,143)	(7,857,143)
Plus Depreciation	6,849,701	6,838,400	6,830,365	7,001,124	7,176,152
Cash Flow to Discount	$ (5,833,588)	$ (4,648,846)	$ (5,392,589)	$ (4,294,556)	$ (4,205,492)
Discount Periods	0.500	1.500	2.50	3.50	4.50
Present Value Factor	0.9492	0.8551	0.7704	0.6940	0.6252
Present Value of Periodic Cash Flows	$ (5,536,997)	$ (3,975,215)	$ (4,154,224)	$ (2,980,491)	$ (2,629,441)
Sum of PV Periodic Cash Flows		$ (19,276,368)			
Perpetuity Value	$ 7,700,000				
PV of Perpetuity Value		$ 4,814,346			
Business Enterprise Value Before Adjustments		**$ (14,462,022)**			
Adjustments to Value:					
Less: Market Required Working Capital Balance		$ (29,972,852)			
Add: Working Capital to be Transferred		6,800,000			
Excess/(Deficit) Working Capital		$ (23,172,852)			
Business Enterprise Value After Adjustments		**$ (37,634,874)**			
Rounded Value		**$ -**			

Schedule 1B – DCF Stand Still (Continued)

DEVELOPMENT OF WACC - GWHN - "Stand-Still"					
			Cost of Capital	% in Capital Structure	Weighted Cost
Debt			3.22%	45%	1.45%
Equity			16.52%	55%	9.09%
Weighted Average Cost of Capital					10.54%
Concluded WACC					**11.00%**
Cost of Equity					
Risk Free Rate of Return		2.62%			
Plus Equity Risk Premium					
Market Risk Premium[1]	5.00%				
Times Beta	1.20				
Adjusted Market Risk Premium		6.00%			
Plus Size Premium[2]		5.90%			
Plus Company Specific Risk Premium		2.0%			
Indicated Cost of Equity		**16.52%**			
Cost of Debt					
Concluded Pre-Tax Cost of Debt	5.35%				
Income Tax Rate	39.88%				
Concluded After-Tax Cost of Debt		**3.22%**			
Selected Yields and Interest Rates					
Rates as of 09/01/2015					
Prime Rate			3.25%		
5-Year Treasury Rates			1.49%		
10-Year Treasury Rates			2.17%		
20-year Treasury Rates			2.62%		
Moody's Aaa			4.15%		
Baa			5.35%		

(1) Long-horizon expected equity risk premium recommended by Duff & Phelps 2015 Valuation Handbook
(2)Estimated based on Duff & Phelps 2015 Valuation Handbook - Guide to Cost of Capital

Schedule 1C – Guideline Company Approach – Stand Still
Adjusted Base Year

Guideline Company Approach - Schedule 1C

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

(1) Adjusted upward 20% to account for a control premium

(2) Information from Yahoo Finance and SEC annual and quarterly reports.

Waterbury Hospital 0.5%

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

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

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

Schedule 1D – Guideline Transaction Approach

Transactions of Hospitals with Net Losses

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

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

Average	**0.43**	**$196,514**	**-11.3%**
Median	**0.41**	**$189,565**	**-4.6%**
High	**0.96**	**$458,716**	**-0.4%**
Low	**0.05**	**$15,152**	**-74.4%**

Schedule 1D – Guideline Transaction Approach

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

Summary and Reconciliation of Assets Transferred

In arriving at the value of the assets transferred, we considered four different indicators under the three different appraisal approaches. In determining a final estimate, we weighted each approach giving consideration to the strengths and weakness of each indication. Based upon this weighting, we derived an overall value estimate of $25,400,00 for the assets to be transferred. Based upon a Consideration of $45,000,000 for the assets transferred there is a Net Financial Benefit associated with the asset sale to Prospect Medical. This calculation is shown on the following table.

Greater Waterbury Health Network
Summary and Conclusion of Assets to Transfer

		Indicated Value	Weighting	Weighted Contribution
Adjusted Book Value Approach	Schedule A	$18,550,000	60%	$11,130,000
Discounted Cash Flow Approach	Schedule B	$0	0%	$0
Market Based Approaches				
Guideline Company Approach	Schedule C	$21,400,000	15%	$3,210,000
Guideline Transaction Approach	Schedule D	$44,100,000	25%	$11,025,000
Total Weighted Value of Assets Transferred				**$25,400,000**
Total Consideration Given for Assets Transferred				**$45,000,000**
Net Benefit of Assets Transferred				**$19,600,000**

The following table summarizes the value of the assets to be contributed and purchased against the benefits that GWHN can reasonably anticipate to achieve given the assumptions and expectations associated with the proposed transaction as contained herein. Based upon a comparison of these economic expectations, it is our conclusion that the transaction is fair from a financial point of view as the value received is greater than the value of the assets purchased.

Greater Waterbury Health Network Summary and Conclusion of Fairness From a Financial Point of View	
Total Weighted Value of Assets Transferred	**$25,400,000**
Total Consideration Given for Assets Transferred	**$45,000,000**
Net Benefit of Assets Transferred	**$19,600,000**
Total Financial Benefit of Transaction	***$19,600,000***

EXHIBIT Q8-1

PHM FISCAL YEAR 2014 AUDITED FINANCIAL STATEMENTS

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended
September 30, 2014 and 2013

The report accompanying these financial statements was issued by BDO USA, LLP, a Delaware limited liability partnership and the U.S. member of BDO International Limited, a UK company limited by guarantee.

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended September 30, 2014 and 2013

Prospect Medical Holdings, Inc.

Contents

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Independent Auditor's Report

Board of Directors
Prospect Medical Holdings, Inc.
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect Medical Holdings, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of income, statements of stockholder's deficit, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect Medical Holdings, Inc. and its subsidiaries as of September 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BDO USA, LLP

December 17, 2014

Consolidated Financial Statements

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2014	2013
Assets		
Current assets:		
Cash and cash equivalents	$ 39,072	$ 86,315
Restricted cash	4,976	563
Investments, primarily restricted money market funds	642	637
Patient accounts receivable, net of allowance for doubtful accounts of $49,727 and $28,050	123,733	75,606
Due from government payers	42,518	27,408
Other receivables	15,947	8,034
Income taxes receivable, net	57	2,365
Deferred income taxes, net	68,304	8,254
Inventories	10,448	4,679
Hospital fee program receivable	-	18,895
Prepaid expenses and other current assets	14,317	8,967
Total current assets	320,014	241,723
Property, improvements and equipment, net	229,474	126,532
Deferred financing costs, net	9,457	11,625
Deferred income taxes, net	-	6,361
Goodwill	158,864	158,864
Intangible assets, net	35,274	31,325
Other assets	8,234	2,516
Total assets	$ 761,317	$ 578,946

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2014	2013
Liabilities and Stockholder's Deficit		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 39,314	$ 30,352
Accounts payable and other accrued liabilities	88,218	52,151
Accrued salaries, wages and benefits	53,808	30,057
Hospital fee program liability and deferred revenue	2,806	8,609
Due to government payers	26,584	19,634
Income taxes payable, net	5,879	1,288
Revolving line of credit	20,000	-
Current portion of capital leases	4,691	5,429
Current portion of long-term debt	133	178
Other current liabilities	1,659	485
Total current liabilities	243,092	148,183
Long-term debt, net of current portion	421,755	420,889
Deferred income taxes, net	70,447	24,869
Malpractice reserves	4,590	4,660
Capital leases, net of current portion	10,463	11,816
Asset retirement obligations	4,310	-
Other long-term liabilities	7,866	570
Total liabilities	762,523	610,987
Commitments, contingencies and subsequent events		
Stockholder's deficit:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2014 and 2013	1	1
Additional paid-in capital	18,457	15,334
Accumulated deficit	(28,481)	(47,496)
Total stockholder's deficit attributable to Prospect Medical Holdings, Inc.	(10,023)	(32,161)
Non-controlling interests	8,817	120
Total stockholder's deficit	(1,206)	(32,041)
Total liabilities and stockholder's deficit	$ 761,317	$ 578,946

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Income
(in thousands)

For the Years Ended September 30,	2014	2013
Revenues:		
Net Hospital Services revenues	$ 618,956	$ 518,206
Provision for bad debts	(32,945)	(34,067)
Net Hospital Services revenues less provision for bad debts	586,011	484,139
Medical Group revenues	253,980	221,743
Other revenues	14,525	7,700
Total net revenues	854,516	713,582
Operating Expenses:		
Hospital operating expenses	449,742	348,961
Medical Group cost of revenues	185,342	164,457
General and administrative	133,056	99,935
Depreciation and amortization	23,580	16,814
Impairment of intangible assets	-	3,476
Total operating expenses	791,720	633,643
Operating income from unconsolidated joint venture	3,356	2,217
Operating income	66,152	82,156
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	41,437	38,860
Gain on bargain purchase	(4,817)	-
Other expense	419	244
Total other (income) expense, net	37,039	39,104
Income before income taxes	29,113	43,052
Income tax provision	10,561	9,810
Net income	18,552	33,242
Net income attributable to non-controlling interests	(463)	7
Net income attributable to Prospect Medical Holdings, Inc.	$ 19,015	$ 33,235

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Stockholder's Deficit
(in thousands except share amounts)

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Deficit	Non-controlling Interests	Total Stockholder's Deficit
Balance at September 30, 2012	100	$ 1	$ 11,634	$ 19,269	$ 30,904	$ 113	$ 31,017
Options exercised	-	-	105	-	105	-	105
Stock-based compensation	-	-	3,595	-	3,595	-	3,595
Distribution to Ivy Holdings Inc. (Parent)	-	-	-	(100,000)	(100,000)	-	(100,000)
Net income	-	-	-	33,235	33,235	7	33,242
Balance at September 30, 2013	100	1	15,334	(47,496)	(32,161)	120	(32,041)
Stock-based compensation	-	-	2,673	-	2,673	-	2,673
Investment in Chaparral Medical Group (see Note 1)	-	-	450	-	450	-	450
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	9,160	9,160
Net income	-	-	-	19,015	19,015	(463)	18,552
Balance at September 30, 2014	100	$ 1	$ 18,457	$ (28,481)	$ (10,023)	$ 8,817	$ (1,206)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2014	2013
Operating activities		
Net income	$ 18,552	$ 33,242
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	23,580	16,814
Amortization of deferred financing costs, net	2,218	2,071
Amortization of original issue discount and premium, net	992	1,002
Provision for bad debts	32,945	34,067
Deferred income taxes, net	(8,111)	(340)
Stock-based compensation	2,673	3,595
Income from equity method investments	(178)	-
Impairment of intangible assets	-	3,476
Loss on disposal of assets	-	28
Gain on bargain purchase	(4,817)	-
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(50,596)	(47,956)
Due to/from government payers, net	(8,827)	(14,962)
Prepaid expenses and other current assets	(1,682)	560
Hospital fee program receivable	18,895	14,578
Inventories	(814)	(12)
Hospital fee program liability and deferred revenue	(5,803)	(11,168)
Income taxes payable/receivable, net	6,899	(10,286)
Deposits and other assets	1,338	(960)
Accrued medical claims and other healthcare costs payable	8,962	3,367
Accounts payable and other accrued liabilities	16,177	11,831
Net cash provided by operating activities	52,403	38,947
Investing activities		
Purchases of property, improvements and equipment	(50,107)	(14,283)
Cash paid for acquisitions, net of cash received and working capital adjustments	(58,300)	(3,085)
Cash paid for investment in Chaparral Medical Group, Inc. (see Note 1)	(1,100)	-
Change in note receivable (net)	66	63
Increase in restricted investments	(5)	(3)
Net cash used in investing activities	(109,446)	(17,308)
Financing activities		
Borrowings of 2019 Notes	-	102,000
Borrowings on line of credit, net	20,000	-
Repayments of long-term debt	(176)	(211)
Repayments on SCH Culver City Creditors Trust Note	-	(500)
Repayments of capital leases	(5,435)	(4,370)
Cash paid for deferred financing costs, net	(50)	(3,948)

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows (Continued)
(in thousands)

For the Years Ended September 30,	2014	2013
Change in restricted cash	(2,676)	(300)
Cash paid for lender consent fees - 2019 Notes	-	(8,914)
Distribution to Ivy Holdings Inc. (Parent)	-	(100,000)
Proceeds from exercises of stock options and warrants	-	105
Repayments of insurance premium financing	(1,863)	(1,613)
Net cash provided by (used in) financing activities	9,800	(17,751)
(Decrease) Increase in cash and cash equivalents	(47,243)	3,888
Cash and cash equivalents, beginning of year	86,315	82,427
Cash and cash equivalents, end of year	$ 39,072	$ 86,315
Supplemental disclosure of cash flow information		
Interest paid	$ 37,608	$ 32,435
Income taxes paid, net	$ 12,004	$ 20,438
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 2,028	$ 4,274
Building lease capitalized	$ -	$ 5,675
Tenant improvement allowance	$ -	$ 1,227
Conversion of note payables to capital leases	$ -	$ 804
Insurance premium financed	$ 1,842	$ 1,635
Long-term liability assumed from acquisition of PCC (see Note 4)	$ 6,440	$ -

See accompanying notes to the consolidated financial statements.

1. Organization

Prospect Medical Holdings, Inc. ("Prospect" or the "Company" or the "Parent Entity") is a Delaware corporation and a wholly owned indirect subsidiary of Ivy Holdings Inc. ("Ivy Holdings").

During the year ended September 30, 2013, the Company incorporated Prospect Health Plan, Inc. ("PHP"), a Delaware corporation and a wholly owned indirect subsidiary of Prospect. On November 4, 2014, the California Department of Managed Health Care ("DMHC") approved PHP's application and issued its license to operate as a Knox-Keene Health Care Service Plan for the purpose of managing "plan-to-plan" contracts with fully licensed Medicare Advantage ("MA") health plans. As part of the strategic effort to expand the Company's plan-to-plan global capitation structure into other geographic markets, Prospect Health Services, Inc. ("PHS") and Prospect Health Services RI, Inc. ("PHSRI") were incorporated during the year ended September 30, 2014, in Texas and Rhode Island, respectively. Collectively, PHP, PHS, and PHSRI will become a new segment in Prospect's operations. For the year ended September 30, 2014, PHP, PHS, and PHSRI did not have any operations.

The Company's operations are currently organized into three primary reportable segments: Hospital Services, Medical Group and Corporate, as discussed below.

Hospital Services Segment

The Company owns 13 acute care and behavioral hospitals and extended care facilities in Southern California, the Greater San Antonio, Texas region, and Rhode Island with a total of 2,258 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries, Southern California Healthcare System, Inc. ("SCHS"), Alta Los Angeles Hospitals, Inc. ("Alta Los Angeles Hospitals"), Alta Newport Hospital, Inc., Prospect Hospital Holdings, LLC ("Nix Health"), and Prospect CharterCARE, LLC ("PCC") (collectively, the "Hospital Services segment"). The Hospital Services segment subsidiaries are wholly owned by Prospect, except for PCC, in which Prospect has an 85% interest (see Note 4).

Effective January 1, 2013, the Company merged its Brotman Medical Center subsidiary into its Alta Hollywood Hospitals, Inc. subsidiary. The surviving entity was renamed Southern California Healthcare System, Inc. on June 26, 2013. In connection with the merger, the Company changed the names of the hospitals owned by SCHS to Southern California Hospital at Hollywood ("SCH Hollywood") fka Hollywood Community Hospital, Southern California Hospital at Van Nuys ("SCH Van Nuys") fka Van Nuys Community Hospital, and Southern California Hospital at Culver City ("SCH Culver City") fka Brotman Medical Center.

Effective April 16, 2013, Nix Health acquired Community General Hospital of Dilley, Texas, Inc., through its newly created subsidiary, Nix Community General Hospital, LLC ("Nix CGH"). Nix CGH operates a hospital with 18 licensed beds in the city of Dilley, Texas.

Effective May 6, 2014, Prospect acquired substantially all of the assets and associated real estate of Newport Specialty Hospital ("NSH") through Prospect's newly created subsidiary, Alta Newport Hospital, Inc., and Bellflower Medical Center (subsequently renamed Los Angeles Community Hospital at Bellflower or "LACH Bellflower") through Prospect's subsidiary Alta Los Angeles Hospitals, Inc. NSH, located in Tustin, California, was substantially closed in 2013 except for its pediatric sub-acute unit. LACH Bellflower, located in Bellflower, California, was closed in 2013 and has been non-operational since that time. Prospect intends to fully reopen both facilities, including maintaining the NSH pediatric sub-acute unit.

Effective June 20, 2014, Prospect acquired, through its subsidiary, PCC, substantially all of the assets of CharterCARE Health Partners and its subsidiaries. PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("Roger Williams Medical Center"), Prospect CharterCARE SJHSRI, LLC ("St. Joseph Health Services of Rhode Island"), and Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), which include hospitals, medical centers and assisted living facilities located in Rhode Island with 785 licensed beds (collectively, "CharterCARE"). PCC is 85% owned by Prospect and 15% by CharterCARE Community Board (formerly known as CharterCARE Health Partners).

The Company's three community hospitals in Hollywood, Los Angeles and Norwalk offer a comprehensive range of medical and surgical services, including general acute care hospital services, pediatrics, obstetrics and gynecology, pediatric sub-acute care, general surgery, medical-surgical services, orthopedic surgery, and diagnostic, outpatient, skilled nursing and urgent care services. The Company's psychiatric hospital in Van Nuys provides acute inpatient and outpatient psychiatric services on a voluntary basis. SCH Culver City offers a comprehensive range of inpatient and outpatient services, including general surgery, orthopedic, spine, cardiology, diagnostic outpatient, rehabilitation, psychiatric and detox services. In addition, SCH Culver City has an active emergency room that plays an integral part in providing emergency services to the West Los Angeles area.

Nix Health provides comprehensive service offerings at various locations throughout the greater San Antonio, Texas region. These locations include Nix Medical Center, which provides inpatient acute care, geriatric psychiatry services, and emergency room services, Nix Specialty Health Center, which provides a full range of behavioral health and rehabilitation services for children, adolescents, and adults, and a range of health clinics and provider based clinics throughout San Antonio, Texas, and Nix CGH, which operates an inpatient acute hospital in Dilley, Texas and a medical clinic in Pearsall, Texas. Nix Health also opened a 73-bed behavioral health center during the year ended September 30, 2014, which provides psychiatric emergency services and crisis intervention unit.

CharterCARE provides a comprehensive range of services at both Roger Williams Medical Center and St. Joseph's Health Services Rhode Island as well as multiple levels of elder care at Elmhurst Extended Care.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid (Medi-Cal in California) and other third party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed, prepaid monthly fees known as "capitation" payments. The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with all medical services. Prospect currently manages the provision of prepaid healthcare services for its affiliated physician organizations in Southern California. The network consists of the following physician organizations as of September 30, 2014 (stand alone or individually referred to as, an "Affiliate"):

Prospect Medical Group, Inc. ("PMG")
Prospect Health Source Medical Group, Inc. ("PHS")

Prospect Professional Care Medical Group, Inc. ("PPCM")
Genesis HealthCare of Southern California, Inc. ("Genesis")
Prospect NWOC Medical Group, Inc. ("PNW")
StarCare Medical Group, Inc. ("PSC")
AMVI/Prospect Medical Group ("AMVI/Prospect")
Nuestra Familia Medical Group, Inc. ("Nuestra")
Upland Medical Group, a Professional Medical Group ("UMG")*
Pomona Valley Medical Group, Inc. ("PVMG")*

* PVMG and UMG are collectively referred to as the "ProMed Entities."

These Affiliates are managed by the following two medical management company subsidiaries that are wholly-owned by Prospect:

Prospect Medical Systems, Inc. ("PMS")
ProMed Healthcare Administrators ("PHCA")

All of the Affiliates are wholly-owned by PMG, with the exception of Nuestra, which was 66.95% owned by PMG as of September 30, 2014, and AMVI/Prospect which is a 50/50 Joint Venture between AMVI Care Health Network, Inc. ("AMVI") and PMG. The operations of all of these entities, with the exception of AMVI/Prospect, are consolidated in the accompanying consolidated financial statements. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement described below.

PMG's ownership in Nuestra increased from 62% as of September 30, 2013 to 66.95% as of September 30, 2014. On October 7, 2013, Nuestra repurchased 109 shares from a physician shareholder that left Nuestra's group medical practice for a de minimis purchase price in accordance with Nuestra's Agreement Concerning Shares of the Company dated September 19, 1995. The repurchase increased the share percentage holdings of all remaining shareholders and Prospect's percentage rose to 66.95% as of October 7, 2013.

The AMVI Joint Venture was formed for the sole purpose of combining enrollment in order to meet minimum enrollment levels required for participation in the CalOptima Medicaid (Medi-Cal in California) program in Orange County, California. The joint venture ownership is set at 50/50 to prevent either party from exerting control over the other; however, AMVI's and PMG's businesses are operated autonomously, and enrollees, financial results and cash flows are each separately tracked and recorded. In accordance with the joint venture partnership agreement, profits and losses are not split in accordance with the partnership ownership interest, but rather, are directly tied to the results generated by each separate portion of the business. Separate from any earnings the Company generates from PMG's portion of business within the joint venture, the Company also earns fees for management services PMS provides to PMG's partner in the joint venture. The Company accounts for PMG's interest in the joint venture partnership using the equity method of accounting. The Company includes in the consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to the Company, together with the management fee that PMS charges for managing those enrollees specifically assigned to the other joint venture partner.

PMS has entered into an assignable option agreement with PMG and the nominee physician shareholder of PMG. Under the assignable option agreement, Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion. The Company may also assign the assignable option agreement to any person. The assignable option agreement has an initial term of 30 years and is

automatically extended for additional terms of 10 years each, as long as the term of the related management services agreement described below (the "Management Agreement") is automatically extended. Upon termination of the Management Agreement with PMG, the related Stock Option would be automatically and immediately exercised. The Stock Option may be exercised for a purchase price of $1,000. Under these nominee shareholder agreements, Prospect has the unilateral right to establish or effect a change of the nominee, at will, and without the consent of the nominee, on an unlimited basis and at nominal cost throughout the term of the Management Agreement. In addition to the Management Agreement with PMG, Prospect, through one of its management company subsidiaries, has a management agreement with each Affiliate. The term of the Management Agreements is generally 30 years. PMG is the sole shareholder of PHS, PPCM, Genesis, PNW, PSC, UMG, and PVMG.

The Company's Affiliates have entered into Management Agreements with PMS or PHCA, as applicable (each of which is a wholly-owned subsidiary of Prospect). Each Affiliate has agreed to pay a management fee to PMS or PHCA, as applicable. The fee is based in part on the costs to the management company and on a percentage of revenues the Affiliate receives (i) for the performance of medical services by the Affiliate's employees and independent contractor physicians and physician extenders, and (ii) for all other services performed by the Affiliates. The revenue from which this fee is determined includes medical capitation, all sums earned from participation in any risk pools and all fee-for-service revenue earned. The management fee also includes a fixed amount for marketing and public relations services. Except in the case of Nuestra and AMVI/Prospect, the Management Agreements had initial terms of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. Effective September 1, 2013, the Managements Agreements for the ProMed Entities were consolidated under one new Management Agreement with PHCA. Effective October, 1, 2013, the Management Agreements for the rest of the Affiliates, other than Nuestra and AMVI/Prospect, were consolidated under one new Management Agreement with PMS. Those two new Management Agreements with PHCA and PMS include initial five year terms and are renewable for successive five year periods thereafter. In the case of Nuestra, its Management Agreement had an initial 10 year term renewable for successive one year terms, subsequently amended in January 15, 2009 to an initial 20 year term renewable for two 10 year periods. In the case of AMVI/Prospect, the Management Agreement has a one year term with successive one year renewal terms. In return for payment of the management fee, Prospect (through PMS and PHCA) has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, Prospect has assumed the obligations for all facilities, medical and non-medical supplies, and employment of non-physician personnel of its affiliated medical clinics.

The management fee earned by Prospect fluctuates based on the profitability of each wholly-owned Affiliate. Prospect is allocated a 50% residual interest in any profits after the first 8% of the profits. The remaining balance is retained by the Affiliates.

The Management Agreements are not terminable by the Affiliates except in the case of gross negligence, fraud or other illegal acts of Prospect, or bankruptcy of the Company.

Further, Prospect's rights under the Management Agreements are unilaterally saleable or transferable. Based on the provisions of the Management Agreements and the assignable option agreement with PMG, Prospect has determined that it has a controlling financial interest in the Affiliates, with the exception of AMVI/Prospect. Consequently, under applicable accounting principles, Prospect consolidates the revenues and expenses of all the Affiliates except AMVI/Prospect from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of AMVI/Prospect, only that portion of the results which are contractually

identified as Prospect's are recognized in the consolidated financial statements, together with the management fee that the Company charges AMVI for managing AMVI's share of the joint venture operations.

Prospect has also entered into management agreements with unaffiliated third parties to manage services to their HMO enrollees. These management agreements do not have characteristics that give rise to the consolidation of the entities under current accounting literature.

The affiliated physician organizations provided medical services to a combined total of approximately 264,600 and 186,100 HMO enrollees as of September 30, 2014 and 2013, respectively. The enrollees include approximately 87,000 and 34,400 enrollees that the Company manages for the economic benefit of six independent third parties, and for which the Company earns management fee income as of September 30, 2014 and 2013, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2014 and 2013 was 2,785,000 and 2,193,000, respectively.

Effective October 1, 2012, the Company, through its newly created affiliate, New Genesis Medical Associates, Inc. ("NGMA"), dba Genesis Medical Clinic, acquired substantially all of the assets of a physician medical practice located in Orange County, California. NGMA is controlled through a nominee shareholder arrangement like the Stock Option structure utilized for PMG and discussed above.

On December 19, 2013, the Company, through its subsidiary NGMA, purchased stock of Chaparral Medical Group, Inc. ("CMG"), a California medical corporation. Consideration was composed of $1,100,000 in cash at the closing, $700,000 in future cash consideration to be used for the acquired company's general corporate purposes, and 3,750 shares of Ivy Holdings common stock issued at closing to the selling shareholders. After payment of the entire consideration, including the future cash consideration, Prospect will own 17.29% of the stock of CMG. Pursuant to the terms of the stock purchase agreement, Prospect will have the right and option to make additional stock investments at the same share valuations and prices and upon the same applicable terms and conditions as the initially acquired shares, to bring its aggregate ownership up to 50%. CMG is a 60 physician multi-specialty group serving communities primarily in the Los Angeles and San Bernardino counties. The Company accounts for NGMA's interest in CMG using the equity method as the Company has the ability to exercise significant influence over the operating and financial policies of CMG.

Corporate Segment

The Corporate segment reflects certain expenses incurred at the Parent Entity not specifically allocable to the Hospital Services or Medical Group segments. These include, but are not limited to: salaries, benefits and other compensation for corporate employees; financing expenses; insurance expenses; rent; legal fees; and accounting fees. The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of all controlled subsidiaries, which control is effectuated through ownership of voting common stock or by other means, but do not include the accounts of the parent companies, Ivy Holdings and Ivy Intermediate Holding Inc.

The Medical Group entities (subsidiaries) have been determined to be variable interest entities due to the existence of a call option under which the Company has the ability to require the holders of all of the voting common stock of the underlying subsidiaries to sell their shares at a fixed nominal price ($1,000) to another designated physician chosen by the Company. This call option agreement represents rights provided through a variable interest other than the equity interest itself that caps the returns that could be earned by the equity holders. In addition, the Company has a management agreement with the subsidiaries and the holders of the voting common stock of the subsidiaries which allows the Company to direct all of the activities of the subsidiaries, retain all of the economic benefits and assume all of the risks associated with ownership of the subsidiaries. In this manner, the Company has all of the economic benefits and risks associated with the subsidiaries but has disproportionately few voting rights (based on the terms of the equity). As the Company retains all of the economic benefits and assumes all of the risks associated with ownership of the subsidiaries, the Company is considered to be the primary beneficiary of the activities of the subsidiaries and therefore must consolidate the underlying subsidiaries.

Operating results for NGMA, Nix CGH, CMG, NSH and LACH Bellflower, and PCC are consolidated with the Company's financial statements from their acquisition dates or inception date in the case of LACH Bellflower (October 1, 2012, April 16, 2013, December 19, 2013, May 6, 2014, and June 20, 2014 respectively) (see Note 4). All significant intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Certain reclassifications were made to the 2013 consolidated financial statements in order to conform to the 2014 presentation.

Revenues

Revenues by reportable segment are comprised of the following amounts (in thousands):

For the Years Ended September 30,	2014 *(a)*	2013 *(b)*
Net Hospital Services		
Inpatient	$ 440,961	$ 403,183
Outpatient	96,802	63,382
Capitation	70,077	44,923
Other	11,116	6,718
Total Hospital Services revenues	618,956	518,206
Less: Provision for bad debts	(32,945)	(34,067)
Total net Hospital Services revenues less provision for bad debts	586,011	484,139
Medical Group		
Capitation	244,573	215,971
Management fees	6,586	2,352
Other	2,821	3,420
Total Medical Group revenues	253,980	221,743
Other revenues	14,525	7,700
Total net revenues	$ 854,516	$ 713,582

(a) CMG, NSH, and PCC revenues have been included in the accompanying consolidated financial statements for the period from acquisition, December 19, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014.

(b) NGMA and Nix CGH revenues have been included in the accompanying consolidated financial statements for the period from acquisition, October 1, 2012 and April 16, 2013, respectively, through September 30, 2013.

Hospital Services Segment

Net Patient Service Revenues

Operating revenue of the Hospital Services segment consists primarily of net patient service revenue. The Company reports net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others in the period in which services are rendered. The Company has agreements with third-party payers, including Medicare, Medicaid (Medi-Cal in California), managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

The following is a summary of sources of patient service revenues (net of contractual allowances and discounts) before provision for bad debts:

September 30,	2014	2013
Medicare	$ 224,984	$ 211,482
Medicaid	189,668	158,048
Managed Care	95,853	77,390
Self Pay/Other	27,258	19,645
Capitation	70,077	44,923
Other	11,116	6,718
Total	$ 618,956	$ 518,206

A summary of the payment arrangements with major third-party payers follows:

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons with end-stage renal disease and certain other beneficiary categories. Inpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Outpatient services are paid based on a blend of prospectively determined rates and cost-reimbursed methodologies. The Company is also reimbursed for various disproportionate share and Medicare bad debt components at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare fiscal intermediary. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

Cost report settlement estimates are recorded based upon as-filed cost reports and are usually not adjusted until a final Notice of Program Reimbursement ("NPR") is issued. The latest updated SSI ratios for 2012 were issued on June 12, 2014. To date, the Company has received final NPRs for Brotman Medical Center, Inc. through 2011 for cost report years prior to its merger into the Alta Hollywood Hospitals, Inc. subsidiary, SCH Hollywood through 2010, Alta Los Angeles Hospitals through 2010, and Nix Health through 2011. Additionally, the Company joined a second round of litigation relating to Medicare's recent settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, Alta Los Angeles Hospitals, SCH Culver City, and CharterCARE recognized a net benefit of $2,495,000, $1,230,000, and $1,672,000, respectively, during the year ended September 30, 2014 related to the Rural Floor litigation.

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the Medicaid program at prospectively determined rates for both inpatient and outpatient services. Medi-Cal is the version of the federal Medicaid program that is applicable to California residents. Inpatient services rendered to Medi-Cal fee-for-service program beneficiaries in California are in the process of a three-year transition to payment at prospectively determined rates based on diagnosis related groups from a contracted per diem rate. Outpatient services are paid based on prospectively determined rates per procedure provided. Inpatient and outpatient services rendered to Medi-Cal managed care beneficiaries in California are paid at either contracted rates or at the Medi-Cal fee-for-service rates. The SCHS and Alta Los Angeles Hospitals are eligible to participate in the State of California Medi-Cal Disproportionate Share ("DSH") programs, under which medical facilities that serve a disproportionate number of low-income patients receive additional reimbursements. Eligibility is determined annually based on prescribed guidelines. Prior to the merger of SCH Culver City with the SCH Hollywood and SCH Van Nuys Hospitals, SCH Culver City did not participate in the program. The Company accrues revenue based on the expected total annual DSH awards. Differences between the estimated and the actual awards are recorded in the period they become known. DSH amounts are subject to retrospective revision prior to finalization and such revisions could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional DSH revenues are recorded when the amounts are received. The Medi-Cal DSH receivable as of September 30, 2014 and 2013 totaled approximately $9,094,000 and $5,437,000, respectively, and were included in due from government program payers in the accompanying consolidated balance sheets. For fiscal years ended September 30, 2014 and 2013, total Medi-Cal DSH payments received by the SCHS and Alta Los Angeles Hospitals were approximately $16,325,000 and $11,618,000, respectively, and total Medi-Cal DSH revenues recorded were approximately $20,475,000 and $11,218,000, respectively. Additionally, pursuant to an audit of Medi-Cal cost reports and notification sent to the Company, the Company accrued a cost report liability payable to Medi-Cal of $1,803,000 and $1,316,000 as of September 30, 2014 and 2013, respectively.

During the fourth quarter of fiscal 2011, the Company's SCHS and Alta Los Angeles Hospitals received notification that the DSH amounts received related to the State fiscal year 2009-2010 were being re-examined and that the DSH amounts to be received for State fiscal years 2010-2011 would be significantly reduced. The notification was the result of legislation that extended payments under Senate Bill 90 ("SB 90"). During the year ended September 30, 2013, the Company recorded a reduction of $2,146,000 in Medi-Cal DSH revenue related to this matter. The matter had no impact on Medi-Cal DSH revenue during the year ended September 30, 2014.

Certain of the Company's California hospitals also participate in *the California Hospital Fee Program* (see Note 10).

In Texas, the Medicaid program reimburses under prospectively determined rates for both inpatient and outpatient services. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program. Nix Health has also been receiving payments from the Texas Health and Human Services Commission under the Section 1115 Waiver ("the waiver") that was recently granted to the state of Texas by CMS. Under the first year of the waiver ending September 30, 2012, a transition payment was paid to Nix Health based upon prior levels of payment under the "Upper Payment Limit" ("UPL") program, which the waiver replaced. Payments for years two through five under the waiver are based upon two pools. One pool is for payments for uncompensated care ("UCC") which includes the shortfall in Medicaid reimbursement as compared to cost and the cost of providing services to uninsured patients. The other pool is the Delivery System Reform Initiative Payments ("DSRIP"), where approved programs and services are undertaken to improve access and services provided. Programs are established by regions and approved by the Texas Health and Human Services Commission and CMS. These programs are assigned a value and milestones are established to measure success and the timing and level of payment from the DSRIP funds. Nix Health recorded revenue related to the UCC pool of $12,366,000 and $12,804,000 for the years ended September 30, 2014 and 2013, respectively. Revenue recorded related to the DSRIP pool was $9,801,000 and $7,078,000 for the years ended September 30, 2014 and 2013, respectively. At September 30, 2014 and 2013, amounts receivable under the Section 1115 Waiver totaled $23,145,000 and $14,781,000, respectively.

Nix Health also recorded $5,746,000 and $9,477,000 during the years ended September 30, 2014 and 2013, respectively, in costs for rural community provision of services. At September 30, 2014 and 2013, amounts payable related to such costs amounted to $0 and $4,754,000, respectively.

The CharterCARE hospitals are participants in the State of Rhode Island's DSH program, which was established in 1995 to assist hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the CharterCARE hospitals, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. Total DSH payments received and revenues recorded by the CharterCARE hospitals were $3,524,000 from June 20, 2014 (acquisition date) through September 30, 2014. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The CharterCARE hospitals recorded $4,036,000 of expense from June 20, 2014 through September 30, 2014 as a result of the license fee.

Managed Care: The Company has also entered into payment agreements with certain commercial insurance carriers, HMOs, and PPOs. The basis for payment under these agreements is in accordance with negotiated contracted rates or at the Company's standard charges for services provided. Some of these payments are capitated, meaning that the Company receives an agreed amount per patient for providing an agreed range of services.

Self-Pay: Self-pay patients represent those patients who do not have health insurance and are not covered by some other form of third party arrangement. Such patients are evaluated, at the time of services or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid, as well as the Company's local hospital's indigent and charity care policy.

See "Concentrations of Credit Risks" below for discussion of revenues received from the Medicare and Medicaid programs.

The Company accrued $895,000 of liabilities as of September 30, 2013 for ongoing Recovery Audit Contractor ("RAC") audits and other similar programs. Effective August 29, 2014, CMS provided a simplified process and timely partial payment to settle certain previously denied claims with dates of service prior to October 1, 2013 whereby such claims under appeal that had been retracted by CMS were settled with the provider receiving 68% of the face value. As a result, the Company recorded $3,887,000 in revenue during the year ended September 30, 2014 related to claims which were previously subject to ongoing RAC audits and other similar programs.

SCH Culver City Outlier Liability

Following the acquisition of a majority stake in SCH Culver City, effective April 14, 2009, the Company consolidated SCH Culver City's estimated liability to CMS arising out of outlier payments received for services provided by the hospital to Medicare eligible inpatients, primarily for the last four months of calendar year 2005 and all of calendar year 2006.

While SCH Culver City reports financial statements on a fiscal year ending September 30, Medicare cost reports are filed on a calendar year basis. Acute care hospitals receive Medicare reimbursement payments pursuant to a prospective payment methodology primarily based on the diagnosis of the patient, but are entitled to receive additional payments, referred to as "outliers" for patients whose treatment is very costly. When Brotman Medical Center, Inc. acquired the hospital in 2005, CMS provided a ratio of cost to charges (the "RCC") based on the statewide average. Payments received by SCH Culver City on this basis were an interim estimate, subject to final determination upon auditing of SCH Culver City's cost reports. SCH Culver City filed its Medicare cost reports, but determined that its outlier reimbursement for services provided in fiscal years 2005, 2006 and part of 2007 might be subject to adjustment based on certain outlier reconciliation rules. On October 12, 2012, SCH Culver City received from its Medicare fiscal intermediary a proposed outlier adjustment for Medicare fiscal year 2006 in the amount of $12,785,000. SCH Culver City had previously been notified of an adjustment of $2,149,000 for 2005. As of September 30, 2014 and 2013, the Company has accrued $13,834,000 of the estimated $14,934,000 liability to CMS included in the accompanying consolidated balance sheets. The difference between the $14,934,000 asserted by CMS and the $13,834,000 accrued by the Company relates to accrued interest of approximately $1,100,000. The Company does not agree, however, with the outlier reconciliation liability. Accordingly, in accordance with relevant literature related to accounting for contingencies, the Company has recorded to the lower end of the range. In March 2013, the Company received a notice of program reimbursement for the 2006 cost report year which approximated the October 2012 adjustment. The Medicare fiscal intermediary has placed the recoupment on hold while the Company is currently in discussions with CMS to resolve this issue. The ultimate resolution of this item is unknown at this stage. The Company has also filed an appeal of the outlier issue with the Provider Reimbursement Review Board for the 2006 cost reporting period since it received a notice of program reimbursement for the 2006 cost report. The ultimate resolution of this appeal is unknown at this stage.

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The following is a summary of due from and due to governmental payers at September 30 (in thousands):

September 30,	2014	2013
Due from government payers:		
Medi-Cal Disproportionate Share (DSH)	$ 9,094	$ 5,437
Medicare cost report settlements	10,279	7,191
Medicaid Section 1115 receivable	23,145	14,780
	$ 42,518	$ 27,408
Due to government payers:		
Outlier liability	$ 13,834	$ 13,834
Medicare cost report settlements	10,947	4,484
Medi-Cal cost report settlements	1,803	1,316
	$ 26,584	$ 19,634

The Company is not aware of any material claims, disputes, or unsettled matters with any payers that would affect revenues that have not been adequately provided for and disclosed in the accompanying consolidated financial statements.

Charity Care

The Company provides charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients with income levels between 300% and 350% of the Federal Poverty Level qualify to pay a discounted rate under the requirements of California State Assembly Bill 774 (AB 774) based on various government program reimbursement levels. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $2,029,000 and $1,003,000 for the years ended September 30, 2014 and 2013, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges of operating expenses, excluding depreciation, interest and management fees.

Provisions for Contractual Allowances and Bad Debts

Collection of receivables from third-party payers and patients is the Company's primary source of cash and is critical to its operating performance. The Company closely monitors its historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions for contractual allowances are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be materially different from the amounts management estimates and records. The Company's primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. Payments for services may also be denied due to issues over patient eligibility for medical coverage, the Company's ability to demonstrate medical necessity for services rendered and payer authorization of hospitalization.

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable increased from 27% at September 30, 2013 to 29% at September 30, 2014. The allowance for doubtful accounts was $49,727,000 and $28,050,000 for the years ended September 30, 2014 and 2013, respectively. The increase in the allowance for doubtful accounts as a percent of gross accounts receivable and in the allowance for doubtful accounts was due primarily to CharterCARE, which was acquired during the year ended September 30, 2014 and had an allowance for doubtful accounts of $16,839,000 at September 30, 2014.

Legislation

All of the Company's hospital facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements.

See Note 10 regarding the *Affordable Care Act*.

Other Revenues

Other revenues consist primarily of the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases, and totaled $14,525,000 and $7,700,000 for the years ended September 30, 2014 and 2013, respectively.

A summary of other revenues recorded during the years follows:

Rural Floor settlement: The Company entered into a settlement agreement with CMS and recognized $6,091,000 of revenue during the year ended September 30, 2014 related to the Rural Floor litigation.

Meaningful Use incentives: The American Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology or adopt or implement such technology. The Medicare incentive payments will be paid out to qualifying hospitals over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physicians must meet EHR "meaningful use" criteria that become more stringent over three stages.

Medicaid programs and payment schedules vary from state to state. The Medicaid programs require hospitals to register for the program prior to 2016, to engage in efforts to adopt, implement or upgrade certified EHR technology in order to qualify for the initial year of participation, and to demonstrate meaningful use of certified EHR technology in order to qualify for payment for up to three additional years.

For the years ended September 30, 2014 and 2013, the Company recorded revenues of $5,389,000 and $5,872,000, respectively, related to the Medicare and Medicaid programs in the consolidated statements of income. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rents is recorded on the straight-line method over the terms of the related lease agreements. During the years ended September 30, 2014 and 2013, the Company recorded rental revenues of $2,220,000 and $1,600,000, respectively.

Medical Group Segment

Medical Group Revenues

Operating revenue of the Medical Group segment consists primarily of payments for medical services procured by the Affiliates under capitated contracts with various managed care providers including HMOs. Capitation revenue under HMO contracts is prepaid monthly to the Affiliates based on the number of enrollees electing any one of the Affiliates as their health care provider. See "Concentrations of Credit Risks" below for revenues received from the five largest contracted HMOs.

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the Affiliates are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each individual enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments,

periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Company received and recorded as additional revenue, approximately $8,889,000 and $6,145,000, respectively, in positive capitation risk adjustments during the years ended September 30, 2014 and 2013, respectively.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the Affiliate can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2014 and 2013, Medical Group revenues included approximately $2,406,000 and $2,880,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2014 and 2013, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $5,547,000 and $6,365,000, respectively, based on the available information from the health plans.

The Company also receives incentives under "pay-for-performance" programs for quality medical care based on various criteria. These incentives, which are included in other revenues within Medical Group revenues, are generally recorded in the third and fourth quarters of the fiscal year when such amounts are known. Pay-for-performance revenues recorded during the years ended September 30, 2014 and 2013, were $1,886,000 and $2,375,000, respectively.

Management fee revenue is earned in the month the services are rendered. Management fee arrangements with unaffiliated entities provide for compensation ranging from 6.5% to 12.5% of revenues. Management fee revenues recorded during the years ended September 30, 2014 and 2013, were $6,586,000 and $2,352,000, respectively.

Medical Group Cost of Revenues

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. See Note 12 for changes in claims estimates during the years ended September 30, 2014 and 2013.

In addition to contractual reimbursements to providers, the Company also makes discretionary incentive payments to physicians, which are in large part based on the pay-for-performance and shared risk revenues and favorable senior capitation risk adjustment payments received by the Company. Since the Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known, the Company also finalizes

the discretionary physician bonuses in the same periods. During the years ended September 30, 2014 and 2013, the Company recorded discretionary physician incentives expense totaling approximately $5,067,000 and $3,993,000, respectively. As of September 30, 2014 and 2013, physician bonus accruals of approximately $4,339,000 and $2,623,000, respectively, were included in accounts payable and other accrued liabilities.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Property, Improvements and Equipment

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over five to ten years, buildings are depreciated over five to 28 years, equipment is depreciated over two to five years and furniture and fixtures are depreciated over two to seven years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset.

As more fully described in Note 10, the Company is required to comply with certain seismic standards as required by the state of California by January 1, 2020. The useful life of buildings subject to seismic retrofit requirements may be limited if the Company does not make the necessary upgrades by the required compliance date.

Goodwill and Other Intangible Assets

Goodwill totaled approximately $158,864,000 at both September 30, 2014 and 2013 and arose as a result of the ProMed, Alta, SCH Culver City, and Nix Health (including Nix CGH) acquisitions. Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. A two-step impairment test is used to identify potential goodwill impairment and to measure the amount of goodwill impairment loss to be recognized, if any. The Company has four reporting units with goodwill, consisting of the Alta Hospitals (which include SCH Hollywood, SCH Van Nuys, Los Angeles Community Hospital, and Norwalk Community Hospital), SCH Culver City, Nix Health, and ProMed (which includes other affiliated physician organizations).

The Company tests for goodwill impairment as of September 30 each year. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the

guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. The Company's impairment test related to goodwill at September 30, 2014 resulted in no impairment charge.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets totaled approximately $35,274,000 and $31,325,000, net of accumulated amortization at September 30, 2014 and 2013, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health, NGMA, and PCC acquisitions. Intangible assets include customer relationships, trade names, favorable leasehold, and physician guarantees. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the year ended September 30, 2014. During the year ended September 30, 2013, the Company changed the original names of the SCHS Hospitals and expects to transition into the new names over the next three years. As a result of the change, the Company recorded an impairment charge of $3,476,000 at September 30, 2013 related to the trade names (see Note 5).

Medical Malpractice Liability Insurance

The individual physicians who contract with the Affiliates carry their own medical malpractice insurance. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. During the year ended September 30, 2013, the SCHS Hospitals and Alta Los Angeles Hospitals were covered under one professional and general liability insurance policy, and Nix Health was covered under a separate policy. Effective October 1, 2013, the hospitals renewed the professional and general liability insurance under one consolidated policy with separate retentions for each entity that runs through September 30, 2014. LACH Bellflower, NSH, and CharterCARE were included under the consolidated policy from their respective dates of acquisition or inception (LACH Bellflower).

Accounting principles generally accepted in the United States of America require that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits)

based upon an actuarial valuation of the Company's historical claims experience of the Company's hospitals. At September 30, 2014 and 2013, the total gross claims liability was approximately $4,590,000 and $4,660,000 and insurance receivables were $618,000 and $1,487,000, respectively, and were estimated using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is continually monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of medical malpractice liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential medical malpractice claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law and that the employer's liability limits are $1,000,000 (excluding Nix Health and CharterCARE). Nix Health has opted out of the Texas Workers' Compensation system as a non-subscriber, and provides its employees with benefits for occupational injury or disease through an ERISA plan. Nix Health has an Employer's Excess Indemnity policy with a $25,000 deductible policy with limits of $10,000,000 per occurrence and $25,000,000 aggregate. CharterCARE was fully insured for workers' compensation claims with no deductible from June 20, 2014 through September 30, 2014. From October 1, 2012 to September 30, 2014, the Company's (excluding Nix Health and CharterCARE) workers' compensation coverage was written on a $250,000 incurred loss retro program without an aggregate loss limitation. At September 30, 2014 and 2013, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $7,210,000 and $4,409,000, respectively. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of the claims liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Asset Retirement Obligations

The Company recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Over time, the liability is accreted to its present value each period. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statement of operations. The Company has accrued $4,310,000 in other long-term liabilities related to asset retirement obligations for the CharterCARE hospitals as of September 30, 2014. There were no asset retirement obligations as of September 30, 2013.

Stock Options

On December 15, 2010, the Board of Directors (the "Ivy Board") of Ivy Holdings adopted the 2010 Stock Option Plan of Ivy Holdings Inc. (the "Ivy Plan") and, on December 16, 2010, the stockholders of Ivy Holdings adopted the Ivy Plan. The Ivy Plan provides that it shall be administered by the Compensation Committee of the Ivy Board. The Ivy Plan includes an Incentive Stock Option Agreement and a Non-Qualified Stock Option Agreement to be used in connection with the grant of options under the Ivy Plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, performance and CEO discretion.

Compensation costs for option awards are measured and recognized in the consolidated financial statements based on their grant date fair value, net of estimated forfeitures over the awards' service period. Options subject to variable accounting treatment are subject to revaluation at the end of each reporting period. The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of stock options granted. The fair value of restricted stock grants are determined on the date of grant, based on the number of shares granted and the quoted price or estimated fair market value of the Company's common stock. Equity-based compensation is classified within the same line items as cash compensation paid to employees.

Cash and Cash Equivalents

The Company considers all highly liquid debt instruments with initial maturities of 90 days or less to be cash equivalents. Cash and cash equivalents are primarily comprised of deposits with banks. The Company maintains its cash at banks with high credit-quality ratings.

Restricted Cash

At September 30, 2014 and 2013, $233,000 was held in a restricted account in connection with workers compensation arrangements, and $30,000 was restricted related to a capitation agreement. At September 30, 2014, a further $420,000 was restricted on behalf of Prospect CharterCARE SJHSRI, LLC for its School of Nursing as required by the U.S. Department of Education, $1,993,000 was restricted for research at CharterCARE hospitals, and $2,300,000 was restricted to meet certain regulatory requirements for PHP. At September 30, 2013, $300,000 was restricted in connection with a statutory deposit required by the Department of Managed Health Care for Knox-Keene licensing related to PHP.

Restricted Investments

The Company is required to keep restricted deposits by certain HMOs for the payment of claims. Such restricted deposits are classified as a current asset in the accompanying consolidated balance sheets, as they are restricted for payment of current liabilities. Investments also include certificates of deposit with maturity dates of more than 90 days when purchased.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or market. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method. On November 16, 2012, the Company issued $100 million of 8.375% senior secured notes (see note 8) and capitalized deferred financing costs of $3,948,000 associated with the

offering during the year ended September 30, 2013, which are reflected in deferred financing costs in the accompanying consolidated balance sheets.

Deferred financing costs at September 30, 2014 and 2013 are as follows (in thousands):

September 30,	2014			2013		
	Gross Book Value	Accumulated Amortization	Net Book Value	Gross Book Value	Accumulated Amortization	Net Book Value
Deferred financing costs	$14,398	$4,941	$9,457	$14,345	$2,720	$11,625

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the statements of operations. For the years ended September 30, 2014 and 2013, no interest and/or penalties related to incomes taxes were accrued and/or expensed.

An entity is required to evaluate its tax positions using a two-step process. First, the entity should evaluate the position for recognition. An entity should recognize the financial statement benefit of a tax position if it determines that it is more likely than not that the position will be sustained on examination. Next, the entity should measure the amount of benefit that should be recognized for those tax positions that meet the more-likely-than-not test.

Consolidated and separate income tax returns are filed with the U.S. Federal jurisdiction and in the State of California, Texas, and Rhode Island. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

The net deferred tax liabilities are primarily comprised of temporary differences between book and tax bases for intangible and capital assets acquired and net operating loss carryforwards.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash investments, patient and other accounts receivables, accrued salaries and benefits, accounts payable and accrued expenses, medical claims and related liabilities, amounts due to government agencies, notes receivable and payable, capital lease obligations, debt, and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value due to the relatively short period of time between the origination of the instruments and their expected realization.

Fair Value Measurement

Relevant accounting guidance establishes a framework for measuring fair value and clarifies that fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants.

The guidance requires disclosure about how fair value is determined for assets and liabilities and establishes a hierarchy for which these assets and liabilities must be grouped, based on significant levels of inputs as follows: Level 1 quoted prices in active markets for identical assets or liabilities; Level 2 quoted prices in active markets for similar assets and liabilities and inputs that are observable for the asset or liability; or Level 3 unobservable inputs for the asset or liability, such as discounted cash flow models or valuations. The determination of where assets and liabilities fall within this hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The Company's Level 1 assets include cash and cash equivalents and investments (certificates of deposit and money market mutual funds). The inputs for fair value of goodwill and intangible assets (including long lived assets and intangible assets subject to amortization) would be based on Level 3 inputs as data used for such fair value calculations would be based on discounted cash flows that are not observable from the market, directly or indirectly.

Financial Items Measured at Fair Value on a Recurring Basis

The following table sets forth the Company's financial assets and liabilities measured at fair value on a recurring basis and where they are classified within the hierarchy (in thousands):

	Total	Level 1	Level 2	Level 3
As of September 30, 2014				
Certificates of deposit and money market mutual funds	$ 642	$ 642	$ -	$ -
As of September 30, 2013				
Certificates of deposit and money market mutual funds	$ 637	$ 637	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

Nonfinancial assets such as goodwill and identifiable intangible assets are measured at fair value when there is an indicator of impairment and recorded at fair value only when impairment is recognized. The Company performs an annual impairment test on the goodwill, and performs an impairment test on the intangibles when there are indications of impairment.

The following table presents the fair value of intangible assets subject to amortization measured at fair value during the year ended September 30, 2013 and included in the Company's consolidated balance sheet as of September 30, 2013 (in thousands):

	Total	Fair Value Measurement Using Level 1	Level 2	Level 3	Total impairment
Trade names	$ 1,940	$ -	$ -	$ 1,940	$ (3,476)

During the year ended September 30, 2013, the Company recorded $3,476,000 of impairment relating to intangible assets subject to amortization, which is reflected in the accompanying consolidated statements of income. No impairment was recorded during the year ended September 30, 2014.

The Company uses the discounted cash flow approach to estimate the fair value of the Company's trade names. The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment as of September 30, 2013:

Fair value of trade names	Valuation Technique	Unobservable Input	Rates
$ 1,940	Discounted cash flow	Weighted average cost of capital	13.0% - 13.5%
		Revenue growth rate	2% - 3%
		Reduction of revenue attributable to trade names	(30%) - (70%)
		Royalty rate	1.0%

Significant increases or decreases in the Company's weighted average cost of capital may result in a significantly lower or higher fair value measurement, respectively. Significant increases or decreases in the revenue growth rate and royalty rates in isolation may result in a significantly higher or lower fair value measurement, respectively. The fair values of the Company's current financial liabilities approximate their reported carrying amounts. The carrying values and the fair values of non-current financial liabilities that qualify as financial instruments under the guidance are as follows (in thousands).

	2014		2013	
September 30,	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	$ 421,888	$ 457,620	$ 421,067	$ 449,339

The fair value of the Company's long-term debt was determined based on market prices.

Concentrations of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, at times, balances may exceed federally insured limits of $250,000 per depositor of each financial institution. The Company has not experienced any losses to date related to these balances.

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare, Medicaid (Medi-Cal in California), patients, health plans including shared-risk arrangements, and notes receivable.

The Company invests excess cash in liquid securities at institutions with strong credit ratings, following established guidelines relative to diversification and maturities to maintain safety and liquidity. These guidelines are periodically reviewed and modified to take into consideration trends in yields and interest rates and principal risk. Management attempts to schedule the maturities of the Company's investments to coincide with the Company's expected cash requirements. Credit risk with respect to receivables is limited since amounts are generally due from large HMOs within the Medical Group Management segment and from the Medicare and Medicaid (Medi-Cal in California) programs within the Hospital Services segment. Notes receivable are fully secured by collateral of equal or greater value. Management reviews the financial condition of these institutions on a periodic basis and does not believe the concentration of cash or receivables results in a high level of risk.

For the years ended September 30, 2014 and 2013, the Hospital Services segment received a total of 67% and 71%, respectively, of its net patient revenues from Medicare and Medicaid programs, and the Medical Group segment received a total of 63% and 69%, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2014	% of Total Revenue	2013	% of Total Revenue
Hospital Services:				
Government Payers:				
Medicare	$ 224,984	36%	$ 211,482	41%
Medicaid	189,668	31%	158,048	30%
Total	$ 414,652	67%	$ 369,530	71%
Medical Group:				
HMO A	$ 33,784	14%	$ 36,194	17%
HMO B	31,632	13%	28,346	13%
HMO C	31,481	13%	31,735	15%
HMO D	31,283	13%	28,754	13%
HMO E	25,133	10%	23,159	11%
Totals	$ 153,313	63%	$ 148,188	69%

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities at the dates, and for the periods, that the consolidated financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include third party settlements, settlements under risk sharing programs, allowances for contractual discounts and doubtful accounts, accruals for medical claims, impairment of goodwill, long-lived assets and intangible assets, share-based payments, professional and general

liability claims and workers' compensation claims, reserves for outcome of legislation and valuation allowances against deferred tax assets.

New Accounting Pronouncements

In June 2011, the FASB issued an accounting standards update that specifies that the liability for the annual fee imposed on certain health insurers under the recently enacted Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. This update is effective for calendar years beginning after December 31, 2013, when the fee initially becomes effective. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In July 2013, the FASB issued an accounting standards update that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In May 2014, the FASB issued ASU No. 2014-09, Revenue from Contracts with Customers (ASU 2014-09). The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2017, including interim periods therein. Three basic transition methods are available – full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. October 1, 2018) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is prohibited. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

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3. Property, Improvements and Equipment

Property, improvements and equipment, consisted of the following (in thousands):

September 30,	2014	2013
Property, improvements and equipment:		
Land and land improvements	$ 53,381	$ 34,985
Buildings and improvements	119,163	59,270
Leasehold improvements	22,967	4,007
Equipment	87,249	64,842
Furniture and fixtures	7,187	5,759
	289,947	168,863
Less: accumulated depreciation	(60,473)	(42,331)
Property, improvements and equipment, net	$ 229,474	$ 126,532

Effective May 6, 2014, Prospect acquired the property, improvements, and equipment of Bellflower Medical Center, located in Bellflower, California, for cash consideration of $20 million. The assets, including land and building, were named Los Angeles Community Hospital at Bellflower. Bellflower Medical Center was closed in 2013 by its previous owner and was not operational since that time. The Company accounted for this transaction as an acquisition of assets. The primary factors influencing the determination that the acquisition should be accounted for in this manner included the complete closure of the hospital, the fact that there were no inputs and/or processes acquired, the requirement for significant additional capital expenditures and development efforts to reopen the hospital, and the lack of acquired workforce. Accordingly, the Company determined that this transaction lacked the key characteristics for business combination accounting. In addition to the $20 million purchase price, Prospect capitalized $546,000 of transaction costs directly related to the purchase of these assets. The purchase price and transaction costs were allocated to the assets acquired based on the relative fair value of the acquired assets.

On July 18, 2013, Nix Health entered into a lease agreement to rent land and building located in the city of San Antonio, Texas, which was used for a 73-bed behavioral health center which was opened during the year ended September 30, 2014. The Company determined that the lease qualified as a capital lease and recorded fixed assets of $5,675,000 and a capital lease liability of $6,902,000 as of September 30, 2013. The difference of $1,227,000 relates to a tenant improvement allowance from the landlord, which was used for construction costs during the year ended September 30, 2014.

During the years ended September 30, 2014 and 2013, the Company made investments of approximately $7,633,000 and $6,200,000, respectively, in equipment related to implementation of EHR technology and new hospital systems at the Company's hospitals.

At September 30, 2014 and 2013, the Company had assets under capitalized leases of approximately $19,294,000 and $17,288,000, respectively, and related accumulated depreciation of $11,465,000 and $7,350,000, respectively.

Depreciation expense was approximately $18,386,000 and $12,443,000 for the years ended September 30, 2014 and 2013, respectively.

4. Acquisitions

Newport Specialty Hospital

Effective May 6, 2014, Prospect acquired substantially all of the assets of Newport Specialty Hospital ("NSH") for cash consideration of $15 million. NSH, located in Tustin, California was substantially closed prior to acquisition, operating only its pediatric subacute unit as of the acquisition date.

The acquisition of NSH was accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. This transaction resulted in a bargain gain of approximately $523,000, which is included in other income in the accompanying consolidated statements of income. The Company incurred $556,000 and $37,000 of transaction costs during the years ended September 30, 2014 and 2013, respectively, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the NSH acquisition, as of May 6, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)
Property, improvements and equipment	$ 15,523
Bargain purchase gain	(523)
Net cash consideration	$ 15,000

CharterCARE

Effective June 20, 2014, Prospect, through its newly formed subsidiary, PCC, acquired substantially all of the assets of CharterCARE Health Partners and its subsidiaries in exchange for a 15% interest in PCC, $43.3 million in cash and a commitment to invest at least $50 million in PCC and its subsidiaries for strategic business development and capital improvements over the next four years. As a result of the acquisition, PCC is owned 85% by Prospect and 15% by CharterCARE Health Partners (which was subsequently renamed CharterCARE Community Board).

PCC, through its subsidiaries, operates Roger Williams Medical Center, St. Joseph Health Services of Rhode Island, and Elmhurst Extended Care Facilities, Inc., which operate hospitals, medical centers and assisted living facilities located in Rhode Island with approximately 785 licensed beds.

The acquisition was accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. This transaction resulted in a bargain gain of approximately $4,294,000, which is included in other income in the accompanying consolidated statements of income. Subsequent to September 30, 2014, the Company received $2,125,000 for a working capital adjustment, which resulted in a reduction in total consideration and an increase in the bargain gain recognized during the year ended September 30, 2014.

The following table summarizes the assets acquired and liabilities assumed in connection with the PCC acquisition, as of June 20, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)
Restricted cash	$ 1,739
Patient accounts receivable and other receivables	34,264
Prepaid expenses and other current assets	8,777
Property, improvements and equipment	53,642
Intangible assets	8,590
Other long-term assets	4,698
Accounts payable and other liabilities	(44,656)
Capital leases	(1,315)
Long-term debt	(25)
Other long-term liabilities	(4,645)
Net assets acquired	61,069
Less: amount attributable to non-controlling interest	(9,160)
Net assets acquired by Prospect	51,909
Total purchase consideration	47,615
Bargain purchase gain	$ 4,294

The total purchase consideration of $47,615,000 includes net cash consideration of $41,175,000 after the working capital adjustment plus a long-term liability of $6,440,000, which represents the discounted fair value of the non-controlling interest's 15% interest in the $50 million future commitment of the Company to PCC as part of the Purchase Agreement. The Company's long-term liability increased from $6,440,000 as of June 20, 2014 to $6,506,000 as of September 30, 2014 due to accretion of the liability.

The Company incurred $2,145,000 and $976,000 of transaction costs during the years ended September 30, 2014 and 2013, respectively, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

New Genesis Medical Associates

On October 1, 2012, the Company, through its newly created affiliate, New Genesis Medical Associates, Inc. dba Genesis Medical Clinic, a California professional medical corporation, acquired substantially all of the assets of a physician medical practice located in Orange County, California. The consideration for the NGMA acquisition consisted of approximately $400,000 in cash. The acquisition of NGMA is accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values.

The following table summarizes the assets acquired in connection with the NGMA acquisition, as of October 1, 2012 (in thousands):

	Purchase Price Allocation
Property, improvements and equipment	$ 50
Intangible assets	350
Net cash consideration	$ 400

Nix Community General Hospital

On April 16, 2013, the Company acquired substantially all of the assets and assumed certain liabilities of Community General Hospital of Dilley, Texas Inc. dba Community General Hospital, a hospital with 18 licensed beds, which offers Dilley, Texas and the surrounding communities an array of medical services including primary care. Upon close of the transaction, the hospital was renamed to Nix Community General Hospital. The consideration for the Community General Hospital acquisition included approximately $2,705,000 in cash, contingent cash consideration of $250,000 and assumption of approximately $795,000 in liabilities, for total consideration of approximately $3,750,000. The acquisition of Community General Hospital is accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. The Company incurred $255,000 of transaction costs during the years ended September 30, 2013, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the Community General Hospital acquisition, as of April 16, 2013 (in thousands):

	Purchase Price Allocation
Current assets	$ 7
Property, improvements and equipment	1,267
Goodwill	2,476
Contingent cash consideration	(250)
Accounts payable and other liabilities	(795)
Net cash consideration	$ 2,705

As an asset purchase, the goodwill and the intangible assets acquired in the PCC, NGMA and Nix CGH acquisitions are deductible for tax purposes.

5. Goodwill and Intangible Assets

As of September 30, 2014 and 2013, goodwill and intangible assets relate to the ProMed, Alta, SCH Culver City, Nix Health, NGMA, Nix CGH, and PCC acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units.

For the Medical Group segment, the Company has determined that PHCA and the ProMed Entities (collectively referred to as "ProMed"), as well as PMS and the other affiliated physician organizations as a group (collectively referred to as "Prospect IPAs") each constitutes a separate reporting unit. NGMA is consolidated within the Prospect reporting unit.

For the Hospital Services segment, the reporting unit for the annual goodwill impairment analysis is determined to be at the business unit level. A separate analysis was prepared for Alta Hospitals, SCH Culver City, and Nix Health. Nix CGH is consolidated within the Nix Health business unit.

During the year ended September 30, 2013, the Company recorded additional goodwill of $2,476,000 related to the Nix CGH acquisition. In addition, the Company recorded a working capital adjustment of $157,000 against the goodwill balance related to the Nix Health acquisition.

The carrying value of goodwill for Alta Hospitals, SCH Culver City, Nix Health (including Nix CGH), and ProMed at September 30, 2014 and 2013 was $106,539,000, $24,373,000, $5,613,000, and $22,339,000, respectively.

The following is a rollforward of goodwill from October 1, 2012 to September 30, 2014 (in thousands):

	Amount
Balance, October 1, 2012	$ 156,545
Acquisition of Nix CGH (see Note 4)	2,476
Working capital adjustments - Nix Health (see Note 4)	(157)
Balance, September 30, 2013	158,864
Balance, September 30, 2014	$ 158,864

Identifiable intangible assets are comprised of the following (in thousands):

	September 30, 2014						
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,596	-	-	-	1,596
Customer relationships	-	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,356	8,590	350	34,650	59,576
Accumulated amortization	(3,670)	(440)	(2,171)	(482)	(100)	(17,439)	(24,302)
Intangible assets, net	$ 6,640	$ 880	$ 2,185	$ 8,108	$ 250	$ 17,211	$ 35,274

	September 30, 2013					
	Alta	SCH Culver City	Nix Health	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	-	9,450	23,820
Favorable leasehold	-	-	20	-	-	20
Physician guarantees	-	-	1,537	-	-	1,537
Customer relationships	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,297	350	34,650	50,927
Accumulated amortization	(2,978)	-	(1,513)	(50)	(15,061)	(19,602)
Intangible assets, net	$ 7,332	$ 1,320	$ 2,784	300	$ 19,589	$ 31,325

During the year ended September 30, 2013, the Company changed the names of the hospitals owned by SCHS to SCH Hollywood, SCH Van Nuys, and SCH Culver City. The fair value of the original trade names at September 30, 2013 was estimated using the relief-from-royalty method and their remaining useful lives were reduced to three years based on the Company's planned use of the trade names. As a result of the valuation, the trade names were valued at $1,940,000 and the Company recorded an impairment charge of $3,476,000 for the year ended September 30, 2013, which is presented as part of operating expenses in the accompanying consolidated statements of income. The Company adjusted the cost basis of the trade names to the new fair value, which resulted in writing off $5,510,000 of gross intangibles and accumulated amortization of $2,034,000. There were no impairments recorded for the year ended September 30, 2014.

During the year ended September 30, 2014 and 2013, intangibles related to physician guarantees, covenants not-to-compete and provider networks of $487,000 and $3,300,000, respectively, were fully amortized and removed from intangible assets.

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2014 and 2013 was approximately $5,194,000 and $4,371,000, respectively.

Estimated amortization expense for each future fiscal year is as follows (in thousands):

Years ended September 30,	
2015	$ 6,345
2016	6,146
2017	4,869
2018	4,632
2019	4,149
Thereafter	9,133
Total	$ 35,274

The following table shows the estimated useful lives for each of the intangible assets:

	Estimated useful lives
HMO membership	14 years
Trade names	3 - 20 years
Favorable leasehold	6 years
Physician guarantees	2 to 3 years
Customer relationships	7 years

The weighted-average remaining useful life for the intangible assets was 7.13 years as of September 30, 2014.

6. Related Party Transactions

Jeereddi Prasad, M.D., a shareholder of Ivy Holdings, a director of Ivy Holdings and the Company, and an officer of the ProMed Entities, has ownership interests in physician medical groups that provide medical services to ProMed members, including CMG. For the years ended September 30, 2014 and 2013, the ProMed Entities paid these groups approximately $12,677,000 and $16,742,000, respectively.

Pursuant to a Management Services Agreement, dated December 15, 2010 and amended on May 3, 2012 (the "LGP Management Agreement"), between the Company and Leonard Green & Partners, L.P. ("LGP"), a private equity fund with affiliated funds that collectively constitute the majority shareholder of Ivy Holdings, LGP provides to the Company, (a) certain investment banking services, (b) management, consulting and financial planning services and (c) financial advisory and investment banking services in connection with major financial transactions from time to time. In consideration for the services provided by LGP under the LGP Management Agreement, the Company pays LGP an annual fee of $1,000,000, payable in monthly installments, and reimburses LGP for its related expenses up to $50,000 annually. If approved by the unanimous consent of the Board of Directors of the Company, additional customary fees may be due to LGP pursuant to the terms of the LGP Management Agreement for services rendered in connection with major transactions from time to time.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. During the years ended September 30, 2014 and 2013, the Company made payments under this arrangement of $5,703,000 and $17,477,000, respectively.

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7. Income Taxes

The components of the income tax provision are as follows (in thousands):

For the years ended September 30,	2014	2013
Current:		
Federal	$ 14,430	$ 8,000
State	4,242	2,184
	18,672	10,184
Deferred:		
Federal	(4,529)	(318)
State	(3,582)	(56)
	(8,111)	(374)
Total:		
Federal	9,901	7,682
State	660	2,128
	$ 10,561	$ 9,810

Temporary differences and carry forward items that result in deferred income tax balances as of September 30 are as follows (in thousands):

September 30,	2014	2013
Deferred tax assets:		
State tax benefit	$ 2,593	$ 2,103
Allowances for bad debts	5,119	4,304
Vacation accrual and other	5,440	4,434
Workers compensation	2,656	1,889
Accrued bonuses	3,898	4,847
Malpractice reserves	1,952	1,204
Deferred rent	107	105
Enterprise zone tax credit	2,433	-
Other	359	379
Net operating losses	8,789	8,798
Capital loss carryforward	2,274	2,255
Deferred tax assets	35,620	30,318
Valuation allowance	(10,737)	(10,742)
Net deferred tax assets	24,883	19,576
Deferred tax liabilities:		
Intangible assets	(7,247)	(8,211)
Fixed assets	(17,664)	(21,038)
Deferred compensation	(112)	-
Partnership outside basis difference	(1,982)	-
Prepaid expenses	(21)	(581)
Deferred tax liabilities	(27,026)	(29,830)
Net deferred tax liabilities	$ (2,143)	$ (10,254)

Deferred tax assets and liabilities reflect the effect of temporary differences between the assets and liabilities recognized for financial reporting purposes and the amounts recognized for income tax purposes.

For the year ended September 30, 2013, the Company released $8,000,000 of deferred tax valuation allowance in connection with net operating losses that became available for use due to the Brotman Medical Center and Alta Hollywood Hospitals merger. The Company maintains approximately $10,737,000 and $10,742,000 as of September 30, 2014 and 2013, respectively, of valuation allowance against its deferred tax assets for capital loss and certain net operation loss carry forwards subject to limitations under tax law. At September 30, 2014, the Company had federal and state net operating loss carryovers of approximately $17,935,000 and $34,039,000 which, if not utilized, will expire beginning 2034 and 2024, respectively. A substantial portion of these net operating loss carry forwards are subject to limitations under Internal Revenue Code Section 382, and their use may be severely limited in the future.

During the year ended September 30, 2013, the Internal Revenue Service ("IRS") concluded its audit of SCH Culver City for the years ended September 30, 2008 through 2010 and its audit of PMG for the year ended September 30, 2010. During the year ended September 30, 2014, the IRS completed its audit of PMH for the year ended September 30, 2010 and the period from October 1, 2010 to December 15, 2010 with no adjustments. The Company's tax years 2010 and after are generally open for federal and state tax examination. At September 30, 2013, the Company has approximately $970,000 of unrealized excess tax benefits related to employee stock options. This amount is not included in the table of deferred tax assets above and the benefit will be recorded as an increase to additional paid in capital if and when realized.

The Company does not have any material unrecognized benefit as of September 30, 2014 and does not anticipate that any material change will occur within the next 12 months.

The differences between the income tax provision at the federal statutory rate and that reflected in the accompanying consolidated statements of operations are summarized as follows:

For the years ended September 30,	2014	2013
Tax provision at statutory rate	35%	35%
State taxes, net of federal benefit	6%	6%
Permanent and other items	0%	3%
Enterprize zone tax credits	(7)%	0%
Change in valuation allowances	0%	(19)%
Other	2%	(2)%
	36%	**23%**

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8. Long-Term Debt

Long-term debt consists of the following (in thousands):

September 30,	2014	2013
Prospect's debt:		
Senior secured notes		
2019 Notes	$ 325,000	$ 325,000
Less: discount, net	(6,339)	(7,641)
	318,661	317,359
Additional 2019 Notes	100,000	100,000
Plus: premium, net	1,419	1,729
	101,419	101,729
Other	-	21
	420,080	419,109
Nix Health's debt:		
Mortgage debt	1,801	1,919
Note payable	-	39
	1,801	1,958
Other debt:	7	-
Total Debt:	421,888	421,067
Less: current maturities	(133)	(178)
Long-term debt, net of current maturities	$ 421,755	$ 420,889

Prospect's Debt:

Senior Secured Notes

On May 3, 2012, the Company closed the offering of $325 million in 8.375% senior secured notes due May 1, 2019 ("PMH 2019 Notes"). Interest is payable semi-annually in arrears on May 1 and November 1, commencing on November 1, 2012. The offering was executed in accordance with Rule 144A and Regulation S under the Securities Act of 1933. The terms of the PMH 2019 Notes are governed by an indenture among the Company, certain of its subsidiaries and affiliates (as "Guarantors"), and U.S. Bank National Association (as trustee) (the "Indenture"). The Indenture contains certain covenants that, among other things, limit the Company's ability, and the ability of its restricted subsidiaries (as such term is defined in the Indenture) to: retire and pay dividends or distributions on capital stock or equity interests, prepay subordinated indebtedness or make other restricted payments; incur additional debt; make investments; create liens on assets; enter into transactions with affiliates; engage in other businesses; sell or issue capital stock of restricted subsidiaries; merge or consolidate with another company; transfer and sell assets; create dividend and other payment restrictions affecting subsidiaries; and designate unrestricted subsidiaries. The Credit Agreement (defined below), executed in connection

with the PMH Senior Secured Credit Facility (discussed below), contains a number of customary covenants as well as covenants requiring the Company to maintain a maximum consolidated secured leverage ratio and limiting the amount of capital expenditures.

Concurrent with the issuance of the PMH 2019 Notes, the Company entered into a five year $50 million revolving senior secured credit facility (the "PMH Senior Secured Credit Facility") which replaced the existing senior secured credit facility. The PMH Senior Secured Credit Facility provides, among other things, for borrowings up to the amount of the facility with sublimits of up to (i) $20 million to be available for the issuance of letters of credit and (ii) $10 million to be available for swingline loans. The commitment under the facility may be increased by up to $10 million upon the Company's request at the discretion of the lenders and subject to certain customary requirements. The interest rate per annum applicable to loans under the PMH Senior Secured Credit Facility will be, at the Company's option, either a rate per annum equal to (i) LIBOR plus 3.50% or (ii) an alternate base rate, which will be the higher of the administrative agent's prime rate, the federal funds rate plus 0.50%, and the 1-month LIBOR rate plus 1.00%, plus in each case, 2.50%. In August 2013, the PMH Senior Secured Credit Facility limit was increased to $60 million. As of September 30, 2014, the Company had $20 million outstanding debt related to the PMH Senior Secured Credit Facility.

The PMH 2019 Notes and the PMH Senior Secured Credit Facility are jointly and severally guaranteed on a senior secured basis by all of the Company's subsidiaries (as such term is defined in the Indenture) other than AMVI/Prospect Medical Group, Nuestra and certain immaterial subsidiaries. The PMH 2019 Notes are secured pari passu with the PMH Senior Secured Credit Facility by first-priority Liens and security interests on substantially all of the tangible and intangible assets of the Guarantors, including, but not limited to, the accounts receivable, inventories, other personal property, real property, fixtures and equipment, in each case now owned or hereafter acquired by the Company and the Subsidiary Guarantors, with certain exceptions. The PMH 2019 Notes are effectively senior to all of the Guarantors' existing and future Indebtedness.

The terms of the PMH Senior Secured Credit Facility are governed by the Credit Agreement, dated as of May 3, 2012, (as amended in connection with the Company's November 2012 offering of additional PMH 2019 Notes - see below) among the Company, Morgan Stanley Senior Funding, Inc. (as administrative agent), Royal Bank of Canada and Credit Suisse AG, Cayman Islands Branch (as co-syndication agents) and the lenders party thereto (the "Credit Agreement").

The Company, at its option, may redeem all or part of the notes at a redemption price equal to 106.281%, 104.188%, 102.094% and 100.0% on or after May 1, 2015, 2016, 2017 and 2018, respectively. Prior to May 1, 2015, the Company, at its option, may (i) redeem up to 35% of the original principal amount of the notes with the proceeds of certain equity offerings at a redemption price of 108.375% (ii) redeem up to 10% of the original principal amount of the PMH 2019 Notes during each 12-month period, commencing on May 1 in each of 2012, 2013 and 2014, at a redemption price of 103.0% of the principal amount thereof (this redemption option was terminated in connection with the Company's November 2012 offering of additional PMH 2019 Notes) or (iii) redeem the PMH 2019 Notes, in whole, but not in part, at a redemption price of 100.0% of the aggregate principal plus a make-whole premium. There are no required principal payments on the PMH 2019 Notes until maturity.

On November 16, 2012, the Company closed the offering of $100 million in aggregate principal amount of 8.375% senior secured notes due 2019 (the "Additional 2019 Notes") at a price equal to 102% of the principal amount of the Additional 2019 Notes. The Additional 2019 Notes were issued in a private placement to qualified institutional buyers and form a part of the same series as the PMH 2019 Notes issued on May 3, 2012.

The Additional 2019 Notes were issued under the Indenture, dated May 3, 2012 and described above, as supplemented by two supplemental indentures entered into in connection with the issuance of the Additional 2019 Notes (the "Supplemental Indentures"). The Additional 2019 Notes are treated as a single series with the previously issued PMH 2019 Notes for all purposes under the Indenture, including, without limitation, restrictive covenants, waivers, amendments, redemptions and offers to purchase. Prior to closing the issuance of the Additional 2019 Notes, the Company was required to obtain the consent of the majority in interest of its PMH 2019 Notes issued on May 3, 2012 to certain amendments to the Indenture contained in the first Supplemental Indenture. The Company obtained such consent from the holders of approximately $324 million in aggregate principal amount of outstanding PMH 2019 Notes and paid an aggregate consent fee of approximately $8.9 million. The Company determined that the transaction represents a debt modification under the applicable accounting guidance and capitalized the consent fee and recorded it as a debt discount during the year ended September 30, 2013, which is being amortized over the term of the Additional 2019 Notes using the effective interest method. As of September 30, 2013, the aggregate outstanding principal balance of the PMH 2019 Notes was $425,000,000, net of unamortized original issue discount of $7,641,000 and plus unamortized original issue premium of $1,729,000.

The proceeds from the offering, together with approximately $10.9 million of the Company's available cash, were utilized to pay a dividend to the stockholders of the Company's indirect parent, Ivy Holdings, in an aggregate amount equal to $100 million, to pay the aforementioned $8.9 million consent fee and to pay approximately $2.5 million for other fees and expenses related to the offering.

In connection with the issuance of the Additional 2019 Notes, the Company entered into an amendment of its Credit Agreement governing the PMH Senior Secured Credit Facility that waived and amended certain provisions of the Credit Agreement, including certain restrictive covenants.

As of September 30, 2014 and 2013, the Company was in compliance with the financial covenants of the Indenture and Credit Agreement.

Demand Notes

During the year ended September 30, 2012, the Company obtained a commitment from a bank for a $9.3 million equipment leasing facility to finance various equipment at the Company's hospital facilities. During January 2014, the commitment was increased to $22.3 million. As of September 30, 2014 and 2013, $10.7 million and $8.4 million, respectively, were drawn under the facility and are classified as capital lease arrangements. Draws represent demand notes until conversion to capital leases, and interest accrues on such draws at the bank prime rate plus 1.5% with a floor of 4.5% and payable monthly.

Nix Health's Debt:

Mortgage Debt

In connection with the Nix Health acquisition, Nix SPE, LLC ("Nix SPE") executed a Loan Assumption Agreement, effective as of February 29, 2012, pursuant to which Nix SPE assumed the obligations of the sellers of Nix Health under a mortgage loan facility provided by The Ohio National Life Insurance Company on December 27, 1999. Nix SPE assumed the obligation to pay the outstanding principal amount of the mortgage loan and interest accruing thereafter. The outstanding balance of the mortgage loan as of September 30, 2014 and 2013 was $1,801,000 and $1,919,000, respectively.

Prospect Hospital Holdings, LLC, the parent company of Nix SPE, has provided a guaranty of the obligations of Nix SPE under the loan. The obligations under the loan facility are secured by a deed of trust on a neighborhood medical center known as Nix Alamo Heights. The loan is subject to a 7.0% interest rate and requires monthly installment payments of $20,674, with a balloon payment on the maturity date of November 1, 2019. Prepayment is subject to a fee and the loan contains customary covenants.

Note Payable

Nix Health entered into a note payable due in March of 2014. Interest accrued on this note at 8.96% and was payable monthly. The outstanding balance of this note as of September 30, 2013 was $39,000, and the note payable was repaid during the year ended September 30, 2014.

Scheduled payments under the Company's current and long-term debt as of September 30, 2014 are as follows (in thousands):

Years ending September 30,	
2015	$ 133
2016	135
2017	145
2018	155
2019	420,247
Thereafter	1,073
	$ 421,888

9. Stockholder's Deficit

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that authorized the issuance of options exercisable for up to 155,110 shares of the common stock of Ivy Holdings to employees, certain consultants and independent members of the boards of directors, of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). During the years ended September 30, 2014 and 2013, the Compensation Committee of the Board of Directors of Ivy Holdings ("Compensation Committee") granted 4,113 and 18,462 options to certain members of the Company's management and employees. These options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, Company and Business Unit performance based on EBITDA targets and CEO and Compensation Committee discretion. Since the Ivy Holdings stock options were granted to Company employees for their services related to the Company, the related compensation cost has been recorded in the Company's consolidated financial statements.

Under the terms of the Ivy Plan, the exercise price of an incentive stock option ("ISO") may not be less than 100% of the fair market value of the Company's common stock on the date of grant and, if granted to a shareholder owning more than 10% of the Company's common stock, then not less than 110%. Stock options granted under the Ivy Plan have a maximum term of 10 years from the grant date, and are exercisable at such time and upon such terms and conditions as determined by the Compensation Committee. Stock options granted to employees generally vest over four years, subject to continued service, performance, and other criteria. In the case of an ISO, the amount of the aggregate fair market

value of common stock with respect to which the ISO grant is exercisable, for the first time by an employee during any calendar year, may not exceed $100,000.

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2014 and 2013 and activity during the years then ended:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of September 30, 2012	112,583	$ 100.00	$ 20.00	104.2
Granted	18,462	120.00	–	–
Exercised	(3,513)	30.00	–	–
Canceled/Forfeited	(9,255)	61.68	–	–
Outstanding as of September 30, 2013 *(1)*	118,277	43.44	76.56	95.8
Granted	4,113	120.00	–	–
Exercised	–	–	–	–
Canceled/Forfeited	(5,957)	58.71	–	–
Outstanding as of September 30, 2014	116,433	$ 45.37	$ 74.63	84.10

(1) The number of options at September 30, 2013 includes 100,611 options modified in connection with the Repricing (see below).

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2014, the aggregate intrinsic value of outstanding shares was approximately $8,700,000. As of September 30, 2014, there were 102,931 options that are exercisable at a weighted average exercise price of $38.01.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2014 and 2013 is presented as follows:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at September 30, 2012	62,657	$ 50.73
Granted	18,462	62.83
Vested	(29,492)	92.53
Canceled/Forfeited	(8,435)	79.53
Nonvested at September 30, 2013 *(2)*	43,192	86.99
Granted	4,113	63.81
Vested	(29,890)	92.00
Canceled/Forfeited	(3,913)	82.72
Nonvested at September 30, 2014	13,502	$ 70.20

(2) The number of non-vested options at September 30, 2013 includes 29,930 options modified in connection with the repricing (see below).

On April 5, 2013, the Compensation Committee approved the repricing of the exercise price of all outstanding stock options as of that date. Pursuant to such resolution of the Ivy Holdings Compensation Committee, as of the effective date, all of the previously granted options were exchanged for new options with a lower exercise price granted on a one-for-one basis. As a result of this repricing, the Company repriced 49,380 vested options and 59,748 unvested options from an original exercise price of $100.00 per share to a new exercise price of $30.00 per share. Other than the exercise price, all other terms of the repriced options, such as vesting and contractual life, remained the same. The Company has accounted for the repricing as a modification and recorded any net incremental fair value related to vested awards as compensation expense on the date of modification. In addition, the Company is recording the incremental fair value related to the unvested awards, together with unamortized stock-based compensation expense associated with the unvested awards, over the remaining requisite service period of the option holders. In connection with the repriced options, the Company recorded stock compensation expense of $1,454,000 on the date of the modification. Incremental compensation cost resulting from the modification was $1,097,000 and $548,000 during the year ended September 30, 2014 and from the modification date through September 30, 2013, respectively.

The original fair value of the options granted ranges from $50.73 to $63.81 per option. In connection with the repricing, the stock compensation expense related to the stock options granted prior to April 5, 2013 is calculated based on a fair value of $97.75. The fair value was determined using the Black-Scholes option pricing model.

Fair value of the repriced options was estimated with the following assumptions for Ivy Holdings:

For the year ended September 30,	2013
Weighted average fair value of repriced options	$97.75
Estimated fair market value of the Company's common stock on the date of grant	$120.00
Weighted average expected life of the options	8.2 years
Risk-free interest rate	1.7%
Weighted average expected volatility	45.9%
Dividend yield	0.00%

Stock-Based Compensation Expense

Stock-based compensation expense for all share-based payments in exchange for employee services (including stock options and restricted stock) is measured at fair value on the date of grant, estimated using an option pricing model and is recognized in the consolidated financial statements, net of estimated forfeitures over the awards requisite service period.

The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of options granted. Estimated forfeitures will be revised in future periods if actual forfeitures differ from the estimates and will impact compensation cost in the period in which the change in estimate occurs. The determination of fair value using the Black-Scholes option-pricing model is affected by the Company's estimated stock price as well as assumptions regarding a number of complex and subjective variables, including expected stock price volatility, risk-free interest rate, expected dividends and projected employee stock option exercise behaviors.

Fair value for options granted during the years ended September 30, 2014 and 2013 was estimated with the following assumptions for Ivy Holdings:

For the years ended September 30,	2014	2013
Weighted average fair value of option grants	$ 63.81	$ 62.83
Estimated fair market value of the Company's common stock on the date of grant	$ 120.00	$ 120.00
Weighted average expected life of the options	8.0 years	8.2 years
Risk-free interest rate	2.7%	1.7%
Weighted average expected volatility	45.0%	45.9%
Dividend yield	0.00%	0.00%

Expected Term - The expected term of options granted represents the period of time that they are estimated to be outstanding.

Risk-Free Interest Rate - The Company bases the risk-free interest rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Volatility—The Company estimates the volatility of the common stock at the date of grant based on the average of the historical volatilities of a group of peer companies. The Company has identified a group of comparable companies to calculate historical volatility from publicly available data for sequential periods approximately equal to the expected terms of the option grants. In selecting comparable companies, Management considered several factors including industry, stage of development, size and market capitalization.

Forfeitures—Share-based compensation is recognized only for those awards that are ultimately expected to vest. Compensation expense is recorded net of estimated forfeitures. Those estimates are revised in subsequent periods if actual forfeitures differ from those estimates. The Company used data since May 2005 to estimate pre-vesting option forfeitures.

Stock-based compensation expense for the Ivy Holdings stock options recognized during the years ended September 30, 2014 and 2013 was approximately $2,673,000 and $3,595,000 (including the impact of the option repricing noted above), respectively. At September 30, 2014, there were 13,502 unvested options which could potentially vest over the next three fiscal years, subject to meeting various vesting requirements which include time, discretion, and various performance targets as defined. The remaining maximum estimated stock compensation expense to be amortized to expense in future periods is approximately $960,000. The stock-based compensation expense is based on a number of criteria, including time, achievement of Company and Business Unit EBITDA targets and CEO and Compensation Committee discretion. Options which are expected to vest based on CEO and Compensation Committee discretion, are treated as variable stock options and are subject to revaluation at each reporting period. Management determined the fair value of the discretionary vested options using a Black Scholes calculation but determined that the change in compensation expense was not material to the consolidated financial statements for the years ended September 30, 2013 and 2014.

Dividends

The Company distributed $100 million in connection with the issuance of the Additional 2019 Notes, during the year ended September 30, 2013, which was recorded against retained earnings, and was ultimately paid to the common stockholders of Ivy Holdings.

10. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through 2026. Certain operating leases contain rent escalation clauses and renewal options, which have been factored into determining rent expense on a straight-line basis over the lease terms. Capital leases bear interest at rates ranging from 2% to 11% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2014, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2015	$ 5,776	$ 5,772
2016	3,215	4,746
2017	2,046	3,821
2018	1,438	3,098
2019	1,217	2,142
Thereafter	7,433	2,503
Total minimum lease payments	21,125	$ 22,082
Less: amounts representing interest	(5,971)	
	15,154	
Less: current portion	(4,691)	
	$ 10,463	

Rent expense for the years ended September 30, 2014 and 2013 was approximately $9,615,000 and $7,365,000, respectively. Sublease rental income of approximately $271,000 and $209,000, for the years ended September 30, 2014 and 2013, respectively, was recorded as a reduction to rental expense.

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

Following the acquisition of the Company in August 2010, two putative class action complaints were filed against the Company, each of the Company's special committee members, Ivy Holdings, LGP, and certain other parties. These complaints, which were consolidated into a single action, allege generally

that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties, in connection with the transaction with the Company by, among other things, authorizing the transaction for what plaintiffs claim to be inadequate consideration and pursuant to what plaintiffs claim to be an inadequate process and with inadequate disclosures. An amended complaint was filed in July 2011 alleging the same general facts.

On December 30, 2010, another lawsuit was filed in Delaware Chancery Court by Terrier Partners and five related entities against the same defendants identified above. The complaint alleges generally that the consideration offered to shareholders in connection with the transaction with the Company was inadequate in light of the revenue received under AB 1383 (see California Hospital Fee Program below), and that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties by not obtaining a higher price in light of this additional revenue.

In May 2012, the Court of Chancery granted motions to consolidate the Terrier Partners case and the class action cases, and for class certification, certifying the class as a non-opt out class. The Court also entered a schedule permitting the plaintiffs to file a new amended complaint, and on June 11, 2012, plaintiffs filed their Verified Consolidated Third Amended Class Action Complaint. On July 26, 2012, the director defendants answered the Third Amended Complaint. That same day, Prospect moved to dismiss itself as a party to the Third Amended Complaint. The Court granted the motion to dismiss the Company as a defendant, leaving only the individuals as defendants in the case.

The parties subsequently engaged in discovery, and agreed to stay the matter in order to explore the possibility of mediation, which was unsuccessful. The defendants have vigorously defended the matter, and will continue to do so. No trial date is currently set.

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

Seismic Standards

Our SCHS Hospitals and Alta Los Angeles Hospitals are required to comply with California's Alfred E. Alquist Hospital Facilities Seismic Safety Act (the "Alquist Act"), which regulates the seismic performance of all aspects of hospital facilities in California. The Alquist Act imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and the retrofitting or replacement of medical facilities to comply with current seismic standards. The Alquist Act also requires that the California Building Standards Commission adopt earthquake performance categories, seismic evaluation procedures, standards and timeframes for upgrading certain facilities, and seismic retrofit building standards. These regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. The Building Standards Commission completed its adoption of evaluation criteria and retrofit standards in 1998.

The Alquist Act requires that within three years after the Building Standards Commission had adopted evaluation criteria and retrofit standards:

- Hospitals in California must conduct seismic evaluation and submit these evaluations to the Office of Statewide Health Planning and Development ("OSHPD"), Facilities Development Division for its review and approval;

- Hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and

- Hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

The Company was required to conduct engineering studies at its hospitals to determine whether and to what extent modifications to the hospital facilities will be required. Management believes that SCH Culver City meets all current requirements; however, it may be required to make significant capital expenditures in the future to comply with the seismic standards, which could impact its earnings. The cost at September 30, 2014, is unknown at this time but could be material. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

The OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as Structural Performance Category ("SPC") 1. These buildings are considered hazardous and at risk of collapse in the event of an earthquake and they were required to be retrofitted, replaced or removed from providing acute care services by 2013, unless granted an extension. OSHPD is using HAZARDS U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings and those that are determined to pose a low seismic risk may be reclassified to SPC-2. The SPC-2 buildings would have until 2030 to comply with the structural seismic safety standards. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 building(s) re-evaluated. Applications for a HAZUS re-evaluation of the seismic risk were submitted for SCH Hollywood, SCH Culver City and Los Angeles Community Hospital, but there is no assurance they will result in extensions.

In addition, in 2011, the California Legislature enacted Senate Bill 90, which permitted some hospitals to apply for up to an additional seven year extension to the seismic retrofit deadlines, not to extend beyond January 1, 2020. SB 90 also permits OSHPD to extend until January 1, 2018 the date by which the hospitals must obtain a building permit and commence the required retrofit project.

SCH Culver City and Los Angeles Community Hospitals both applied for the SB 90 extension from OSHPD. Two of the buildings owned by SCH Culver City were granted SB 90 extensions until January 2019 and July 2019, respectively. Also, the facility operated by Los Angeles Community Hospital received an SB 90 extension until January 2019. All three extensions are contingent upon the delivery of certain additional plans and reports prior to January 2015 that have either been delivered or are in process at the time of this report. OSHPD is still reviewing the SB 90 extension request filed for a third building owned by SCH Culver City, which is also still subject to our application to be reclassified as a SPC-2 building.

OSHPD has discretion to approve or disapprove SB 90 extension requests, and to determine the length of the extension (up to the maximum seven years), based on eligibility factors including seismic risks associated with the affected buildings (which can be impacted by the updated HAZUS findings), community access to essential hospital services in the area and financial hardships facing the applicant.

Effective May 6, 2014, Prospect acquired the hospital facilities NSH and LACH Bellflower (see Note 4). For the newly acquired facilities, the Company is in the process of pursuing Non-Structural Performance Category ("NPC") 2 classification and the extension of the compliance deadlines that would result.

These requirements can result in significant operational changes and capital outlays. Management is continuing to assess its options and the methods of financing the required retrofits. Based on management's evaluation, the costs of renovation needed to comply with the California seismic safety standards for its acute-care facilities, including asbestos abatement, are not estimable at this time.

Legislation and HIPAA

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

The Company believes that it is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

California Hospital Fee Program

The State of California enacted Assembly Bill 1383 ("AB 1383") effective January 1, 2010, as amended by Assembly Bill 1653 (collectively, the "Program"), to provide supplemental payments to certain hospitals such as the hospitals owned and operated by the Company's subsidiaries. The Program requires participating hospitals to pay fee assessments into a pool of funds to which the federal government contributes matching funds. Most of these funds, including the federal matching funds, are then distributed to qualifying hospitals. In addition, on April 13, 2011 SB 90 was signed into law and provided for a six-month extension of the Hospital Fee Program for dates of service from January 1, 2011 through June 30, 2011. CMS granted final approval of SB 90 on December 29, 2011, at which point the revenue and expense was recognized for the retroactive period. In September 2011, the State of California enacted Senate Bill 335 ("SB 335") which provides a 30-month hospital fee program for dates of service from July 1, 2011 through December 31, 2013. The elements of SB 335 related to the fee for service payments were approved by CMS on June 22, 2012. The payments due under the managed care component are scheduled to be made in three cycles. The first two cycles were previously approved by CMS, and the third cycle was approved by CMS subsequent to September 30, 2014. Certain technical changes to the legislation required by CMS are included in Senate Bill 920.

Governor Brown signed Senate Bill 239 ("SB 239") in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. This program was approved by CMS on December 5, 2014. SB 239 provides that the hospital fee program will continue through December 31, 2022 in three year cycles and will require authorization of each cycle by the California legislature. The Company has not recognized any amounts related to SB 239 as of and for the years ended September 30, 2014 and 2013.

For the years ended September 30, 2012 and 2011, SCH Culver City received invoices for fee assessments under AB 1383 and SB 90 of approximately $6,310,000 and $19,000,000, respectively, following payment of which, SCH Culver City was scheduled to receive approximately $5,236,000 and $15,000,000, respectively. Management of SCH Culver City estimated that SCH Culver City would be a "net" payer under the Program, since the fee assessments on SCH Culver City exceeded the supplemental payments by approximately $1,074,000 and $4,000,000, respectively. Accordingly, on October 6, 2010, the Company notified the California Department of Healthcare Services ("DHCS") that SCH Culver City was opting out of the Program.

SCH Culver City did not pay the required fee assessments under the Program. Beginning February 14, 2011, the DHCS began withholding against amounts otherwise due SCH Culver City, in the amount of $65,000 per week indicating that withholdings would continue for 108 weeks and would total approximately $7,000,000. Through September 30, 2012, a total of approximately $2,986,000 had been withheld against SCH Culver City's Medi-Cal fee-for-service payments. As of September 30, 2012, SCH Culver City recorded a liability of approximately $5,494,000, representing the accrued loss above, as well as deferred recognition of payments received from managed care plans. On November 15, 2012 the Company entered into a settlement agreement with DHCS with regards to SCH Culver City's liability under AB 1383, SB 90 and SB 335, as discussed above. Under the terms of the agreement, the DHCS agreed to forgive approximately $2,000,000 of the fees due under AB 1383, which was recorded by the Company during the year ended September 30, 2013. The remaining liability due to DHCS of $4,605,000 will be repaid by the Company monthly over a 10-year period without interest or penalties. The Company recorded a net liability of $3,233,000 as of the settlement date, which represents the net present value of the liability due to DHCS discounted at an effective interest rate of 7.5%. As of September 30, 2014 and 2013, the unamortized balance of the liability amounted to $2,806,000 and $3,046,000, respectively. The DHCS will no longer withhold against any other amounts due to SCH Culver City unless the Company is delinquent on payments owed under the agreement.

As of September 30, 2013, the Company had a receivable related to the California Hospital Fee Program of $18,895,000 in the accompanying consolidated balance sheets. The Company did not have a receivable related to the California Hospital Fee Program as of September 30, 2014. As of September 30, 2014 and 2013, the Company had a liability related to the California Hospital Fee Program of $2,806,000 and $8,609,000, respectively, in the accompanying consolidated balance sheets.

Total California Hospital Fee program revenues and expenses recognized during the years ended September 30, 2014 and 2013 were as follows (in thousands):

Year Ended September 30,	2014	2013
Hospital services revenues	$ 11,884	$ 63,371
Hospital operating expenses	5,863	37,925
Net pre-tax impact	$ 6,021	$ 25,446

Collective Bargaining Agreements

A small group of employees at SCH Hollywood, which is one of the hospitals under the consolidated group of Alta Hospitals System, LLC, and Service Employees International Union, United Healthcare Workers-West ("SEIU") are currently parties to a collective bargaining agreement with a termination date of April 27, 2017. In addition, approximately 77% of the employees of SCH Culver City are part of a collective bargaining agreement with the SEIU or the California Nurses Association ("CNA"). SCH Culver City and CNA are currently parties to a collective bargaining agreement that expires on December 21, 2015. SEIU and SCH Culver City are currently parties to a three-year term agreement that expires on April 27, 2017.

As of September 30, 2014, approximately 25% of the employees at CharterCARE St. Joseph's are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expires July 31, 2016. An additional 1% are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires April 30, 2016.

Tangible Net Equity ("TNE") requirement

The Company's affiliated physician organizations must comply with a minimum working capital requirement, Tangible Net Equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the California Department of Managed Health Care. TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. At September 30, 2014 and 2013, the Company and the affiliated physician organizations were in compliance with these regulatory requirements.

Employee Health Plans

From October 1, 2012 through December 31, 2012, the Company (except for SCH Culver City and Nix Health) was fully insured for its HMO and PPO plans to employees. For the fully insured groups, health benefits were administered by a commercial insurance carrier, based on plan coverage and eligibility guidelines determined by the Company. The insurance policies had guaranteed cost and the Medical Group and Corporate segment incurred no claim liability if terminated. SCH Culver City and Nix were self-insured for their EPO/HMO and PPO plans.

Effective January 1, 2013 the Company offered self-insured EPO/HMO and PPO plans to all eligible employees. The CharterCARE hospitals were not included under such plans from the date of acquisition through September 30, 2014 and have a separate low-deductible plan. Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). A commercial insurance policy covers losses in excess of $250,000 per occurrence for the Hospital Segment and $175,000 for the Medical Group and Corporate segments. An actuarially estimated liability of approximately $1,828,000 and $1,788,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2014 and 2013, respectively.

Provider Contracts

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

11. Defined Contribution Plan

The Company sponsors a defined contribution plan covering substantially all employees who meet certain eligibility requirements. Under this plan, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plan, except at Nix Health and PCC, for which the expense for the employer match was $576,000 and $463,000 for the years ended September 30, 2014 and 2013, respectively. Total expenses under the plan were approximately $197,000 and $87,000 during the years ended September 30, 2014 and 2013, respectively.

12. Accrued Medical Claims and Other Healthcare Costs Payable

The following table presents the roll-forward of incurred but not reported ("IBNR"), claims reserves (Medical Group and full risk contracts) as of and for each of the fiscal years ended September 30, 2014 and 2013 (in thousands):

September 30,	2014	2013
IBNR as of beginning of year	$ 30,352	$ 26,985
Claim expenses incurred during the year:		
Related to current year	161,088	128,747
Related to prior year	(3,571)	(3,646)
Total incurred	157,517	125,101
Claims paid during the year:		
Related to current year	(124,393)	(100,301)
Related to prior year	(24,162)	(21,433)
Total paid	(148,555)	(121,734)
IBNR as of end of year	$ 39,314	$ 30,352

Following is a table showing the details of the medical group cost of revenues per the consolidated statements of operations (in thousands):

Years Ended September 30,	2014	2013
Capitation expense	$ 85,754	$ 76,918
Fee-for-service claims expense	94,749	82,846
Other physician compensation	5,066	3,993
Other cost of revenues	(227)	700
Total cost of revenues	$ 185,342	$ 164,457

13. Joint Venture

The Company (through Prospect Medical Group, Inc.) and an unrelated third party, AMVI Care Health Network, Inc. ("AMVI") are partners in a joint venture initially formed to service Medi-Cal members under the CalOptima program in Orange County, California. Healthy Families and OneCare members were subsequently added to the joint venture arrangement. Effective January 1, 2013, all Healthy Family participants were transferred to the Company's Medi-Cal line of business and therefore no longer part of the joint venture. The Company does not consolidate the joint venture. The Company includes in its consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to it, together with the management fee that it charges the joint venture partner for managing those enrollees specifically assigned to AMVI. Costs incurred by the Company in managing the joint venture are included in general and administrative expenses in the accompanying consolidated financial statements. As of September 30, 2014 and 2013, the net liability balances of the Company investment in the joint venture under the equity method were approximately $1,594,000 and $2,000,000, respectively, and were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

Summarized unaudited financial information for the unconsolidated joint venture as of and for each of the years ended September 30, 2014 and 2013 is as follows (in thousands):

September 30,	2014	2013
Cash	$ 1,753	$ 742
Receivables	2,232	2,037
Total assets	$ 3,985	$ 2,779
Accrued medical claims	$ 1,658	$ 1,556
Other payables	1,470	34
Other partner's capital	856	1,188
Prospect's capital	1	1
Total liabilities and partner's capital	$ 3,985	$ 2,779

Years Ended September 30,	2014	2013
Revenues	$ 19,289	$ 16,307
Income before income taxes	$ 2,915	$ 2,206
Prospect's equity income	$ 3,295	$ 2,150
Management fees earned by Prospect	$ 1,141	$ 1,016

14. Segment Information

The Company's operations are organized into three reporting segments: (i) Hospital Services – which is comprised of the Alta Hospitals, SCH Culver City, Nix Health, and PCC reporting units, owns 13 hospitals or extended care facilities – Los Angeles Community Hospital, Norwalk Community Hospital, Los Angeles Community Hospital at Bellflower, Newport Specialty Hospital, SCH Hollywood, SCH Van Nuys, SCH Culver City, Nix Medical Center, Nix Specialty Health Center, Nix CGH, Roger Williams Medical Center, Saint Joseph's Health Services of Rhode Island, and Elmhurst Extended Care; (ii) Medical Group – which is comprised of the Prospect and ProMed reporting units, provides management services to affiliated physician organizations that operate as independent physician associations or medical practice groups and certain unaffiliated independent physician associations; and (iii) Corporate, which represents expenses incurred in Prospect Medical Holdings, Inc., that were not allocated to the other reporting segments.

The accounting policies of the reporting segments are the same as those described in the summary of significant accounting policies (see Note 2). The Company evaluates financial performance and allocates resources primarily based on earnings from operations before interest expense, interest income, income taxes, depreciation and amortization, as well as income or loss from operations before income taxes, excluding infrequent or unusual items.

The reporting segments are strategic business units that offer different services within the healthcare industry. Business in each reporting segment is conducted by one or more direct or indirect wholly-owned subsidiaries of the Company and certain affiliated physician organizations controlled through assignable option agreements and management services agreements. The Company voluntarily discloses the following table which summarizes certain information for each of the reporting segments regularly provided to and reviewed by the chief operating decision maker (in thousands):

	As of and for the Year Ended September 30, 2014				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 600,536	$ 253,980	$ -	$ -	$ 854,516
Intersegment revenues	-	1,039	-	(1,039)	-
Total revenues	600,536	255,019	-	(1,039)	854,516
Depreciation and amortization	20,694	2,846	40	-	23,580
Operating income (loss)	57,748	29,080	(20,676)	-	66,152
Other (income) expense	(3,037)	(26)	38,480	1,622	37,039
Income (loss) before income taxes	60,785	29,106	(59,156)	(1,622)	29,113
Provision for income tax	-	-	10,561	-	10,561
Net income (loss)	$ 60,785	$ 29,106	$ (69,717)	$ (1,622)	$ 18,552
Identifiable segment assets	$ 599,516	$ 75,612	$ 86,189	$ -	$ 761,317
Segment capital expenditures, net of dispositions	$ 49,181	$ 924	$ 2	$ -	$ 50,107
Segment goodwill	$ 136,525	$ 22,339	$ -	$ -	$ 158,864

	As of and for the Year Ended September 30, 2013				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 491,839	$ 221,743	$ -	$ -	$ 713,582
Intersegment revenues	-	727	-	(727)	-
Total revenues	491,839	222,470	-	(727)	713,582
Depreciation and amortization	14,062	2,715	37	-	16,814
Operating income (loss)	75,199	24,399	(17,442)	-	82,156
Other (income) expense	1,314	(49)	37,839	-	39,104
Income (loss) before income taxes	73,885	24,448	(55,281)	-	43,052
Provision for income tax	-	-	9,810	-	9,810
Net income (loss)	$ 73,885	$ 24,448	$ (65,091)	$ -	$ 33,242
Identifiable segment assets	$ 453,232	$ 117,556	$ 8,158	$ -	$ 578,946
Segment capital expenditures, net of dispositions	$ 13,583	$ 650	$ 50	$ -	$ 14,283
Segment goodwill	$ 136,526	$ 22,338	$ -	$ -	$ 158,864

(1) Prospect files consolidated tax returns and allocates costs for shared services and corporate overhead to each of the reporting segments. With the exception of Nix Health and PCC, all debt, including debt related to the Medical Group and Hospital Services segment, is recorded at the Parent Entity level. The Company does not allocate interest expense related to acquisition debt to the operating segments.

(2) Prospect Medical Group, Inc. (which serves as a holding company for the other affiliated physician organizations) files consolidated tax returns. The Medical Group segment includes the results for NGMA from October 1, 2012 (acquisition date) through September 30, 2014.

(3) The Hospital Services segment includes the results for Nix CGH, Los Angeles Community Hospital at Bellflower and Newport Specialty Hospital, and CharterCARE from the acquisition dates of April 16, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014. Included in revenues from external customers are $14,525,000 and $7,700,000 of other revenues related primarily to the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases for the years ended September 30, 2014 and 2013, respectively.

15. Subsequent Events (Unaudited)

The Company has evaluated subsequent events through December 17, 2014, the date the Company's consolidated financial statements were available for issuance.

Acquisitions

Effective October 21, 2014, the Company, through its subsidiary, Prospect CharterCARE Physicians, LLC ("PCCP"), entered into two separate asset purchase agreements pursuant to which PCCP will acquire substantially all of the assets of physician medical practices located in Rhode Island.

Pursuant to the first purchase agreement, PCCP will acquire substantially all of the assets of Physicians of Rhode Island Medical Enterprises, Inc., a primary care practice group with one physician and five nurse practitioners located in Cumberland, Rhode Island, and PMA, LLC, a primary care practice group with one physician and one nurse practitioner located in Pawtucket, Rhode Island. Pursuant to the same purchase agreement, on October 21, 2014, PCCP acquired 49% of the issued and outstanding membership interests in Partners in Clinical Research, LLC, a clinical research business located in Cumberland, Rhode Island. The Company paid $2,410,000 as consideration under the asset purchase agreement.

Pursuant to the second purchase agreement, PCCP will acquire substantially all of the assets of Physicians of East Side Primary Care, LLC, a primary care practice group with one physician, two physician assistants and one nurse practitioner located in Providence, Rhode Island. The Company paid $860,000 as consideration under this asset purchase agreement. Additionally, on each of the first four (4) anniversaries of the October 21st closing date, the Company will pay to the seller an EBITDA bonus based on the performance of the acquired practice.

The majority of the assets of the groups were acquired on October 21, 2014. However, the acquisition of certain professional licenses and related assets, and the employment of certain professional staff, will occur at a later date after all necessary licensing and credentialing by PCCP has occurred. PCCP and the sellers of the groups have entered into Interim Administrative Services Agreements that will provide for the administration of the seller entities during the period prior to such second acquisition dates. PCCP and the two physicians that are the principal owners of the seller entities have entered into employment agreements and non-compete restrictions. Additionally, PCCP entered into three (3) separate office leases with five (5) year terms that provide for the lease of the spaces currently occupied by the practices. The lessors under each office lease are the employed physicians that are the former principal owners of the groups.

California Hospital Fee Program

Governor Brown signed SB 239 in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. The fee for service component of the program was approved by CMS on December 5, 2014, and the managed care component has not yet been approved. The Company has not recognized any amounts related to SB 239 as of and for the year ended September 30, 2014. The Company anticipates a net benefit from the program for service periods from January 1, 2014 to December 31, 2016.

EXHIBIT Q8-2

PMH FISCAL YEAR 2015 2ND QUARTER UNAUDITED FINANCIAL STATEMENTS

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands, except par value and share amounts)

	June 30, 2015 (unaudited)	September 30, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 34,708	$ 39,072
Restricted cash	4,298	4,976
Investments, primarily restricted money market funds	1,266	642
Patient accounts receivable, net of allowance for doubtful accounts of $53,724 and $49,727	143,810	123,733
Due from government payors	55,100	42,518
Other receivables	24,425	15,947
Income taxes receivable, net	3,685	57
Deferred income taxes, net	68,304	68,304
Inventories	12,373	10,448
Hospital fee program receivable	24,011	-
Prepaid expenses and other current assets	20,674	14,317
Total current assets	392,654	320,014
Property, improvements and equipment, net	237,923	229,474
Deferred financing costs, net	7,789	9,457
Goodwill	161,461	158,864
Intangible assets, net	31,454	35,274
Other assets	9,341	8,234
Total assets	$ 840,622	$ 761,317
LIABILITIES AND STOCKHOLDER'S EQUITY (DEFICIT)		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 50,633	$ 39,314
Accounts payable and other accrued liabilities	94,467	88,218
Accrued salaries, wages and benefits	59,424	53,808
Hospital fee program liability	13,623	2,806
Due to government payors	36,428	26,584
Income taxes payable, net	6,120	5,879
Revolving line of credit	20,000	20,000
Current portion of capital leases	3,285	4,691
Current portion of long-term debt	568	133
Other current liabilities	1,481	1,659
Total current liabilities	286,029	243,092
Long-term debt, net of current portion	422,464	421,755
Deferred income taxes, net	70,447	70,447
Malpractice reserves	6,619	4,590
Capital leases, net of current portion	9,096	10,463
Asset retirement obligations	4,514	4,310
Other long-term liabilities	6,632	7,866
Total liabilities	805,801	762,523
Commitments, Contingencies and Subsequent Events		
Stockholder's equity (deficit):		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at June 30, 2015 and September 30, 2014	1	1
Additional paid-in capital	20,647	18,457
Retained earnings (Accumulated deficit)	3,565	(28,481)
Total Prospect Medical Holdings, Inc.'s stockholder's equity (deficit)	24,213	(10,023)
Noncontrolling interest	10,608	8,817
Total stockholder's equity (deficit)	34,821	(1,206)
Total liabilities and stockholder's equity (deficit)	$ 840,622	$ 761,317

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited, in thousands)

	Three Months Ended June 30,		Nine Months Ended June 30,	
	2015	2014	2015	2014
Revenues:				
Net Hospital Services revenues	$ 238,378	$ 131,472	$ 760,537	$ 383,183
Medical Group revenues	91,018	69,575	235,945	181,795
Net Global Risk Management revenues	813	-	1,389	-
Other revenues	690	1,485	5,465	2,603
Total net revenues	330,899	202,532	1,003,336	567,581
Operating expenses:				
Hospital operating expenses	185,976	102,517	594,046	291,154
Medical Group cost of revenues	52,613	47,121	161,679	134,385
Global Risk Management operating expenses	710	-	1,152	-
General and administrative	49,172	32,864	143,064	86,095
Depreciation and amortization	8,676	5,488	25,212	15,481
Total operating expenses	297,147	187,990	925,153	527,115
Operating income from unconsolidated joint ventures	3,119	1,001	4,133	1,604
Operating income	36,871	15,543	82,316	42,070
Other (income) expense:				
Interest expense and amortization of deferred financing costs, net	10,491	10,282	31,535	30,946
Gain on bargain purchase adjustment	-	(4,068)	318	(4,068)
Other (income) expense	(25)	(50)	(71)	61
Total other expense, net	10,466	6,164	31,782	26,939
Income before income taxes	26,405	9,379	50,534	15,131
Income tax provision	9,579	3,403	18,464	5,934
Net income	16,826	5,976	32,070	9,197
Net income attributable to noncontrolling interest	268	1,489	26	1,503
Net income attributable to Prospect Medical Holdings, Inc.	$ 16,558	$ 4,487	$ 32,044	$ 7,694

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)

	Nine Months Ended June 30,	
	2015	2014 (1)
Operating activities		
Net income	$ 32,070	$ 9,197
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	25,212	15,481
Amortization of deferred financing costs, net	1,668	1,662
Amortization of original issue (premium) discount	810	810
Provision for bad debts	34,634	25,258
Stock-based compensation	2,018	2,018
Undistributed earnings from equity method investments	(172)	-
Gain on sale of assets	(25)	-
Gain on bargain purchase adjustment	318	(4,068)
Gain on sale of equity method investment	(296)	-
Change in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(65,322)	(39,655)
Due to/from government payors, net	(2,737)	(2,876)
Prepaid expenses and other current assets	(1,885)	(2,503)
Hospital fee program receivable	(24,011)	18,895
Hospital fee program liability	10,817	(5,733)
Inventories	(1,927)	17
Income taxes receivable/payable, net	(3,387)	(10)
Deposits and other assets	(33)	298
Accrued medical claims and other healthcare costs payable	11,319	6,852
Accounts payable and other accrued liabilities	13,243	3,937
Net cash provided by operating activities	32,314	29,579
Investing activities		
Purchases of property, improvements and equipment	(28,517)	(41,141)
Proceeds from sale of property and improvements	987	-
Cash paid for acquisitions, net of cash received and working capital adjustment	(895)	(58,300)
Cash paid for equity method investment	(1,880)	(1,100)
Proceeds for partial disposition of equity method investment	1,233	-
Collections from note receivable	52	674
Increase in restricted investments	(624)	(5)
Issuance of note receivable	-	(625)
Net cash (used in) investing activities	(29,644)	(100,497)
Financing activities		
Repayments of long-term debt	(100)	(127)
Borrowings on line of credit, net	-	40,000
Repayments of capital leases	(3,685)	(3,945)
Cash paid for deferred financing costs, net	-	(50)
Change in restricted cash	678	(2,423)
Proceeds from exercises of stock options and warrants	172	-
Repayments of insurance premiums financing	(4,099)	(1,628)
Other, net	-	(17)
Net cash (used in) provided by financing activities	(7,034)	31,811
(Decrease) in cash and cash equivalents	(4,364)	(39,108)
Cash and cash equivalents at beginning of period	39,072	86,315
Cash and cash equivalents at end of period	$ 34,708	$ 47,207

Continued at next page

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)
(continued)

	Nine Months Ended June 30,	
	2015	2014
Supplemental disclosure of cash flow information:		
Interest paid	$ 37,545	$ 36,927
Income taxes paid, net	$ 21,777	$ 6,179
Schedule of non-cash investing and financing activities:		
Equipment acquired under capital leases	$ 905	$ 1,892
Insurance premium financed	$ 4,472	$ 2,122
Long-term liability assumed from acquisition of CharterCARE	$ -	$ 6,440

(1) Certain reclassifications were made to the fiscal 2014 presentation in order to conform to the fiscal 2015 presentation.

EXHIBIT Q10-1: INDEPENDENT FOUNDATION CERTIFICATE OF INCORPORATION (DRAFT)

CERTIFICATE OF INCORPORATION

OF

[NAME OF POST-CONVERSION FOUNDATION]

The undersigned incorporator hereby forms a corporation under the Connecticut Revised Nonstock Corporation Act, Chapter 602 of the Connecticut General Statutes (as the same may hereafter be revised or replaced, the "Nonstock Act"), as follows:

1. *Name.* The name of the Foundation is [NAME OF POST-CONVERSION FOUNDATION] (the "Foundation").

2. *No Members.* The Foundation shall have no members.

3. *Purposes.* The Foundation shall be operated exclusively for charitable, religious, educational, and/or scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding section of any future federal tax code, as amended (the "Code" and referred to by Section reference). That benefit, further, support and carry out the purposes, missions and objectives of [insert WH Service Area municipalities and public charities](the "Supported Organizations") to the extent such purposes, missions and objectives exclusively support or promote the following purposes:

(a) To provide for the healthcare needs of the greater Waterbury area, including the towns of Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown, Wolcott and Woodbury (the "Communities");

(b) To support or conduct community health needs assessments and encourage and support efforts to improve the health of the Communities;

(c) To support and engage in community projects, grants, activities and programs that will improve access to healthcare and enhance the health of the Communities, including the provision of preventive health programs and health education, education and training of healthcare providers and educators in the Communities; and

(d) In furtherance of the foregoing activities and purposes, but subject to the restrictions of this Certificate of Incorporation, the Foundation may engage in any lawful act or activity for which nonstock corporations may be formed under the Nonstock Act.

4. *Nonprofit.* The Foundation is nonprofit and shall not have or issue shares of stock or make distributions unless as expressly provided herein.

5. *Restrictions*. The Foundation shall (i) be empowered only to engage in activities in furtherance of the above-described exclusively charitable, religious, educational and/or scientific

purposes, and (ii) not be empowered to engage in activities that would cause the Foundation to cease to be qualified as exempt under Section 501(a) of the Code as described in Section 501(c)(3) of the Code, or that would cause contributions to the Foundation to cease to be deductible under Section 170(c)(2) of the Code. The Foundation shall be subject to the following additional restrictions and requirements:

(a) The Foundation shall not participate in or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. No substantial part of the activities of the Foundation shall constitute the carrying on of propaganda or otherwise attempting to influence legislation, except to the extent the Foundation makes expenditures for purposes of influencing legislation in conformity with the requirements of Section 501(h) of the Code.

(b) For any period during which it is a "private foundation," as defined in Section 509 of the Code, the Foundation shall distribute its income for each taxable year at such time and in such manner as not to become subject to the tax on undistributed income imposed by Section 4942 of the Code. Among the activities in which the Foundation shall not engage for any period during which it is such a "private foundation" are: (i) any act of self-dealing (as defined in Section 4941(d) of the Code); (ii) retaining any excess business holdings (as defined in Section 4943(c) of the Code); (iii) making any investment in such manner as to subject the Foundation to tax under Section 4944 of the Code; and (iv) making any taxable expenditures (as defined in Section 4945(d) of the Code).

(c) No part of the net earnings of the Foundation shall inure to the benefit of, or be distributable to, its officers, directors, trustees or other private persons, except that the Foundation shall be authorized and empowered to pay reasonable compensation for services rendered, to reimburse reasonable expenses incurred, to purchase goods and services at reasonable prices, and to provide programs, services and other benefits, all in furtherance of the exclusively charitable, religious, educational, and/or scientific purposes of the Foundation set forth in Section 3, and to make distribution of its assets upon dissolution as provided for in Section 9.

6. *Board of Trustees.* All corporate powers shall be exercised by or under the authority of, and the activities, property and affairs of the Foundation shall be managed by or under the direction of its Board of Trustees as set forth in the Bylaws of the Foundation. At least a majority of the Board of Trustees shall be comprised of individuals appointed to the Board of Directors by the Supported Organizations. In the event that a supported Organization ceases to be exempt under Section 501(c)(3) of the Code or becomes a private foundation under section 509(a) of the Code shall immediately cease to be a "Supported Organization" of the Foundation and shall have no rights or powers with respect to the Foundation. A Trustee appointed by any such Supported Organization shall immediately be disqualified and removed from the Board of Trustees.

7. *Limitation of Liability of Trustees to the Foundation*.

(a) Liability Limited. To the fullest extent that the Nonstock Act or any other law of the State of Connecticut, as in effect on the date of this Certificate of Incorporation or as hereafter amended, permits the limitation or elimination of the personal liability of a Trustee of the Foundation to the Foundation, no Trustee shall be liable to the Foundation for monetary damages for breach of duty as a Trustee.

(b) Effect of Limitation. No repeal, modification or amendment of this Section 7 shall adversely affect any right or protection of a Trustee of the Foundation existing at the time of such repeal or modification. Nothing contained in this Section 7 shall be construed to deny to the Trustees of the Foundation the benefit of Section 52-557m of the Connecticut General Statutes as in effect at the time of the violation (or the corresponding provisions of any subsequent statute amending or replacing said statute), if applicable. The provisions of this Section 7 are set forth in this Certificate of Incorporation pursuant to the authority contained in subdivision (4) of subsection (b) of Section 33-1026 of the Nonstock Act and are intended to limit the liability of Trustees of the Foundation to the greatest extent now or hereafter permitted under the laws of the State of Connecticut.

8. *Indemnification of Trustees and Officers; Prepayment of Expenses.*

(a) Right to Indemnification. The Foundation shall indemnify and hold harmless, to the fullest extent permitted by applicable law as it presently exists or may hereafter be amended, any person (an "Indemnitee") who was or is made or is threatened to be made a party to or is otherwise involved in any action, suit or proceeding, whether civil, criminal, administrative or investigative (a "Proceeding"), by reason of the fact that he or she, or a person for whom he or she is a legal representative, is or was a Trustee or officer of the Foundation, or while a Trustee or officer of the Foundation, is or was serving at the request of the Foundation as a director, trustee, officer, employee or agent of another corporation or of a partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity, including service with respect to employee benefit plans, against all liability (as defined in Section 33-1116 of the Nonstock Act) and loss suffered by such Indemnitee for any action taken, or any failure to take any action, by the Indemnitee. Notwithstanding the preceding sentence, except as otherwise provided in paragraph (c) of this Section 8, the Foundation shall be required to indemnify an Indemnitee in connection with a Proceeding (or part thereof) commenced by such Indemnitee only if the commencement of such Proceeding (or part thereof) by the Indemnitee was authorized by the Board of Trustees of the Foundation.

(b) Prepayment of Expenses. Subject to the last sentence of paragraph (a) of this Section 8, the Foundation shall pay the expenses (including attorneys' fees) incurred by an Indemnitee in defending any Proceeding in advance of its final disposition; provided, however, that, to the extent required by law, such payment of expenses in advance of the final disposition of the Proceeding shall be made only upon receipt of (1) a written affirmation of the Indemnitee as required under Section 33-1119 of the Nonstock Act and (2) an undertaking by the Indemnitee to repay all amounts advanced if it should be ultimately determined that the Indemnitee is not entitled to be indemnified under this Section 8 or otherwise.

(c) Claims. Subject to the last sentence of paragraph (a) of this Section 8, if a claim for indemnification or payment of expenses under this Section 8 is not paid in full within sixty (60) days after a written claim therefor by the Indemnitee has been received by the Foundation, the Indemnitee may file suit to recover the unpaid amount of such claim and, if successful in whole or in part, shall be entitled to be paid the expense of prosecuting such claim. In any such action, the Foundation shall have the burden of proving that the Indemnitee is not entitled to the requested indemnification or payment of expenses under applicable law.

(d) Nonexclusivity of Rights. The rights conferred on any Indemnitee by this Section 8 shall not be exclusive of any other rights which such Indemnitee may have or hereafter acquire under this Certificate of Incorporation or any statute, agreement, bylaw, vote of disinterested Trustees or otherwise.

(e) Other Sources. The Foundation's obligation, if any, to indemnify or to advance expenses to any Indemnitee who was or is serving at its request as a director, officer, employee or agent of another corporation, partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity shall be reduced by any amount such Indemnitee may collect as indemnification or advancement of expenses from such other Foundation, partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity.

(f) Amendment or Repeal. Any repeal or modification of the foregoing provisions of this Section 8 shall not adversely affect any right or protection hereunder of any Indemnitee in respect of any act or omission occurring prior to the time of such repeal or modification.

(g) Other Indemnification and Prepayment of Expenses; Employees. This Section 8 shall not limit the right of the Foundation, to the extent and in the manner permitted by law, to indemnify and to advance expenses to persons other than Indemnitees when and as authorized by appropriate corporate action. Without limiting the effect of the foregoing sentence, the Foundation may, if specifically authorized by the Board of Trustees of the Foundation, indemnify and advance expenses to any person who is made a party to or is otherwise involved in a proceeding by reason of the fact that he or she, or a person for whom he or she is a legal representative, is or was an employee of the Foundation, or while an employee of the Foundation, is or was serving at the request of the Foundation as a director, trustee, officer, employee or agent of another corporation or of a partnership, limited liability company, joint venture, trust, enterprise or nonprofit entity, including service with respect to employee benefit plans, against all liability (as defined in Section 33-1116 of the Nonstock Act) and loss suffered by such employee for any action taken, or any failure to take any action, by such employee, to the greatest extent permitted by applicable law.

(h) Interpretation. The provisions of this Section 8 are set forth in this Certificate of Incorporation pursuant to the authority contained in subdivision (5) of subsection (b) of Section 33-1026 of the Nonstock Act and are intended to expand the scope of, and make obligatory on the Foundation, the indemnification of Trustees and officers of the Foundation to the greatest extent now or hereafter permitted under the laws of the State of Connecticut, and to make permissible for the Foundation the indemnification of employees to the greatest extent permitted by applicable law.

(i) Limitation. Notwithstanding any other provision of this Section 8, if at any time the Foundation is a "private foundation," as defined in Section 509 of the Code, the Foundation shall not, during the period it is such a private foundation, indemnify any person if such indemnity or its carrying out will constitute a violation of any provision of Section 33-281(b) of the Connecticut General Statutes or any substantially like provision which may be contained in this Certificate of Incorporation.

9. *Dissolution*. Upon dissolution of the Foundation, the Board of Trustees shall adopt a plan of distribution which shall, after paying or making provision for payment of the liabilities of the Foundation, cause all of the net assets of the Foundation to be distributed to one or more organizations that are described in Section 501(c)(3) of the Code and that are exempt under Section 501(a) of the Code and are established for purposes substantially similar to those of this Foundation as the plan of distribution, adopted in accordance with law, shall provide. Such organization(s) shall be selected by the Superior Court of New Haven County after notice to the Attorney General of the State of Connecticut.

10. *References to Laws*. References to Sections of the 1986 Internal Revenue Code shall include references to the corresponding provisions of any future Internal Revenue Code, and references to any law, regulation, statute or ordinance shall likewise include references to the corresponding provisions of any future law, regulation, statute or ordinance.

11. *Amendment.* In addition to any requirements of the Nonstock Act, as the same may be revised from time to time, any modifications to Sections 3, 5(c), 9 or 11 of this Certificate of Incorporation must receive prior written approval by the Attorney General, and if necessary, additional approval by the Superior Court.

12. *Registered Office and Registered Agent*. The name of the registered agent of the Foundation is _____ whose office address is_____and whose residence address is _____.

13. *Incorporator*. The name and address of the sole incorporator of the corporation is _____, _____, _____.

Signed at_____, Connecticut this ___ day of _____, 201__.

_____

Incorporator

EXHIBIT Q10-2: INDEPENDENT FOUNDATION BYLAWS (DRAFT)

BYLAWS
OF
[NAME OF POST-CONVERSION FOUNDATION]

ARTICLE I
Name, Governing Law, Offices

The name of the corporation is "[Name of Post-Conversion Foundation]" (the "Foundation"). The Foundation shall be governed by the Connecticut Revised Nonstock Corporation Act, Chapter 602 of the Connecticut General Statutes (as the same may hereafter be revised or replaced, the "Nonstock Act"). The registered office of the Foundation shall be at such place in the State of Connecticut as the Board of Trustees of the Foundation (the "Board") shall from time to time designate.

ARTICLE II
Purpose

The purpose of the Foundation shall be as set forth in the Certificate of Incorporation and to provide for the healthcare needs of the greater Waterbury area, including the towns of Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Prospect, Southbury, Waterbury, Watertown, Wolcott and Woodbury (the "Communities").

ARTICLE III
No Members

The Foundation shall have no members.

ARTICLE IV
Trustees

4.1 General; Qualifications. All corporate powers shall be exercised by or under the authority of, and the activities, property and affairs of the Foundation shall be managed by or under the direction of the Board. At least a majority of the Trustees shall live or work in the Communities. Consideration shall be given to a candidate's knowledge of the Communities, skill set, work experience, the diversity of the individual's cultural background ethnicity gender aged and socio economic status. No Trustee shall at the time of appointment or during the year prior to proposed service as a Trustee:

(a) be an employee or a member of the governing board of Greater Waterbury Health Network, Inc. or any of its affiliates (collectively, "GWHN");

(b) be an employee or a member of the governing board or community advisory board of the entity that purchases the assets of The Waterbury Hospital or an affiliate of such entity (collectively, the "Post Closing Hospital").

4.2 Number and Election of Trustees**. [include provisions for election of Trustees by Supported Organizations as necessary.]** There shall be not fewer than nine (9) or more than twelve (12) Trustees. The actual number of Trustees within such minimum and maximum shall initially be [_____] ([__]), and thereafter by prescribed resolution adopted from time to time by the Board. If no number is so prescribed by the Board, the number of Trustee positions shall be equal to the number of Trustees in office immediately after the most recent Annual Board Meeting (as defined in Section 4.4). The total number of Trustees shall be divided into three (3) classes, with each class consisting of one-third of the Trustees or as close to one-third as is practical. The terms of the Trustees shall be staggered so that the terms of one such class of Trustees shall expire at the Annual Board Meeting each year. At each Annual Board Meeting, Trustees shall be elected by the Board for a term of three (3) years to succeed the Trustees in the class whose terms expire at such Annual Board Meeting, except that Trustees may be elected to shorter terms as necessary to fill vacancies or to place or keep the staggered terms in effect. The Board shall be self-perpetuating to the extent that the Board elects the Trustees as set forth above.

4.3 Term Limits.

(a) Subject to Section 4.3(b), Trustees may serve a maximum of three (3) consecutive three-year terms in office, after which such person shall not be eligible to serve as a Trustee for a period of one (1) year. If a Trustee is elected to serve for a term of less than three (3) years, then such term shall not count as a term for purposes of computing term limits. For purposes of computing the time periods referred to in Section 4.2 and this Section 4.3, the full period between consecutive Annual Board Meetings shall be considered one (1) year.

(b) If a Trustee's term expires while the Trustee is serving as Chairman, Vice-Chairman or Secretary, then the Board shall re-elect such Trustee to serve an additional term as Trustee, even if such additional term would exceed the term limits provided in Section 4.3(a).

4.4 Annual Board Meeting. An annual meeting of the Board (the "Annual Board Meeting") for the election of Trustees and Officers, and other appropriate business, shall be held each year at a date, time and place designated by the Board. The Annual Board Meeting shall be considered one of the regular meetings of the Board.

4.5 Regular Meetings of the Board. In addition to the Annual Board Meeting, regular meetings of the Board shall be held at least four times each year in accordance with a schedule established for the year by the Board at each Annual Board Meeting, which may be revised thereafter at any duly called and convened meeting of the Board.

4.6 Special Meetings of the Board. Special meetings of the Board may be held at any time. Special meetings may be called by the President whenever he or she deems it appropriate, and shall be called by the Secretary at the request of any two (2) Trustees.

4.7 Method of Notice; when Notice is Effective; Contents of Notice. Not less than five (5) days' notice by mail, fax, telephone or e-mail shall be given to the Trustees of each regular meeting of the Board. Not less than seven (7) days' notice by mail, fax, telephone or e-

mail shall be given to the Trustees of each special meeting of the Board. Notice of the Annual Board Meeting and any other regular meeting of the Board shall state the date, time and place of the meeting and need not specify the business to be transacted at the meeting unless required by the Nonstock Act, the Certificate of Incorporation or a provision of the Bylaws, and notice of any special meeting of the Board shall state the date, time and place of the meeting and the business to be transacted at the meeting.

4.8 Place of Meetings. The Board may hold its meetings at such place or places within or without the State of Connecticut as the Board may from time to time determine.

4.9 Waiver of Notice. A Trustee may waive any notice required by the Nonstock Act, the Certificate of Incorporation or the Bylaws before or after the date and time stated in the notice. The waiver shall be in writing, signed by the Trustee entitled to the notice, and filed with the minutes or corporate records. Notwithstanding the foregoing, a Trustee's attendance at or participation in a meeting waives any required notice to the Trustee of the meeting unless the Trustee at the beginning of the meeting, or promptly upon the arrival of the Trustee, objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting.

4.10 Quorum. A quorum for the transaction of business at any meeting of the Board shall be a majority of the total number of Trustee positions prescribed at the time, including vacancies, if any.

4.11 Action by the Board. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, except as may otherwise be required by law or by the Certificate of Incorporation or the Bylaws. Each Trustee must act personally; there shall be no voting by proxy, power of attorney or other delegation method.

4.12 Action without Meeting. Any action required or permitted by the Nonstock Act to be taken at a Board meeting may be taken without a meeting if the action is taken by all Trustees. The action shall be evidenced by one (1) or more written consents describing the action taken, signed by each Trustee and included in the minutes or filed with the corporate records reflecting the action taken. Action taken under this section is effective when the last Trustee signs the consent, unless the consent specifies a different effective date. A consent signed under this section has the effect of a meeting vote and may be described as such in any document.

4.13 Telephonic, etc., Meeting. The Board may permit any or all Trustees to participate in a regular or special meeting by, or conduct the meeting through the use of, any means of communication, such as conference telephone communication, by which all Trustees participating may simultaneously hear each other during the meeting. A Trustee participating in a meeting by this means is deemed to be present in person at the meeting.

4.14 Resignation of Trustees. A Trustee may resign at any time by delivering written notice to the Board or the Foundation. A resignation is effective when the notice is delivered unless the notice specifies a later effective date.

4.15 Removal of Trustees. The Board may remove one or more of the Trustees with or without cause at any time by the affirmative vote of two-thirds (2/3) of the Trustees then in office. A Trustee may be removed by the Board only at a meeting called for the purpose of removing the Trustee and the meeting notice must state that the purpose, or one of the purposes, of the meeting is removal of the Trustee.

4.16 Vacancy among Trustees. If a vacancy occurs among the Trustees, including a vacancy resulting from an increase in the number of Trustees: (1) the Board may fill the vacancy; or (2) if the Trustees remaining in office constitute fewer than a quorum of the Board, they may fill the vacancy by the affirmative vote of a majority of all the Trustees remaining in office. The term of a Trustee elected between Annual Board Meetings to fill a vacancy expires at the next Annual Board Meeting. A vacancy that will occur at a specific later date, by reason of a resignation effective at a later date under Section 4.15 or otherwise, may be filled before the vacancy occurs but the new Trustee may not take office until the vacancy occurs.

ARTICLE V
Officers

5.1 General. The Officers of the Foundation shall be: a President, a Vice President, a Treasurer and a Secretary. The Officers of the Board shall be a Chairman and one or more Vice-Chairmen as the Board may prescribe. The Officers shall be elected by the Board at the Annual Board Meeting, or thereafter as the need may arise. Any two (2) or more such offices may be held by the same person. The duties of Officers shall be such as are prescribed by these Bylaws and as may be prescribed by the Board.

5.2 Terms of Office. The Chairman, Vice Chairman, Treasurer and Secretary shall each be elected from among the Trustees and serve for two (2) year terms and until his or her successor shall be duly elected, but any Officer may be removed by the Board at any time, with or without cause. The period between consecutive Annual Board Meetings shall be deemed one (1) year for this purpose. Vacancies among the Officers shall be filled by the Board. Other than the President and Vice-President, an Officer may serve a maximum of two (2) consecutive biannual terms in a given office. Thereafter, such person shall be ineligible to serve in the capacity as that Officer for a period of two (2) years. No Trustee shall be elected as an Officer who has exceeded his or her term limits as Trustee but continues to serve as Trustee as a result of the provisions of Section 4.3(b).

5.3 Chairman. The Chairman shall exercise overall supervision of Board affairs; preside at all meetings of the Board; provide leadership to the Board in formulating, developing and evaluating the policies and goals of the Foundation; represent the Foundation to the community and promote its interests; and appoint the members and chairmen of committees and Advisory Council, as necessary, in consultation with and upon approval of the Board. The Chairman shall also perform such other duties as may be assigned to him or her from time to time by the Board. The Chairman shall be elected from among the Trustees and may not serve as Chairman during any time that he or she is not a Trustee. The Chairman shall be an *ex-officio* member of all committees and shall be counted in determining a quorum and entitled to vote.

5.4 Vice-Chairmen. The Vice-Chairmen shall assist the Chairman in the exercise of his or her duties, and shall perform such other duties as may be assigned to him or her from time to time by the Board. Vice-Chairmen, if any, shall be elected from among the Trustees and may not serve as Vice-Chairmen during any time that he or she is not a Trustee.

5.5 President. The President shall be the Chief Executive Officer of the Foundation, and shall also perform such other duties as shall be assigned to him or her by the Board from time to time. The President may but need not be elected from among the Trustees at the time of election.

5.6 Vice President. Subject to any restrictions imposed by the Board, the Vice President shall perform the duties and have the powers of the President during the absence or disability of the President. The Vice President shall also perform such other duties as may be assigned to him or her by the Board from time to time. The Vice President may but need not be elected from among the Trustees at the time of such election.

5.7 Secretary. The Secretary shall be responsible for preparing and keeping a record of the proceedings of all meetings of the Board and for authenticating records of the Foundation. The Secretary shall issue all notices required by law or by these Bylaws. The Secretary shall have the custody of the seal of the Foundation and all books, records and papers of the Foundation, except as shall be in the charge of the Treasurer or of some other person authorized to have custody and possession thereof by a resolution of the Board, and shall discharge all other duties required of such officer by law or assigned to him or her from time to time by the Board or as are incident to the office of Secretary. The Secretary shall be elected from among the Trustees.

5.8 Treasurer. The Treasurer shall oversee the custody of all funds and securities of the Foundation, shall supervise the keeping of full and accurate accounts of receipts and disbursements of all funds of the Foundation, shall oversee the maintenance of the accounting books and records of the Foundation, and shall supervise the deposit of all monies and valuable effects in the name and to the credit of the Foundation in depositories designated by the Board. The Treasurer shall prepare or cause to be prepared an annual budget for the Foundation and shall submit it to the Board prior to the beginning of each fiscal year of the Foundation. The Treasurer shall prepare or cause to be prepared annual financial statements for the Foundation in form and substance satisfactory to the Board and shall submit such financial statements to the Board prior to each Annual Board Meeting. The Treasurer shall report to the Board periodically on the financial condition of the Foundation in such detail as the Board may request from time to time, and shall discharge all other duties required of such officer by law or assigned to him or her from time to time by the Board or as are incident to the office of Treasurer. The Treasurer shall be elected from among the Trustees.

ARTICLE VI
Committees

6.1 Composition of Committees.

(a) The Board may create committees, which may exercise the power and authority of the Board; provided, however, that each such committee must be composed entirely of two or more persons who are Trustees while they serve on such committee, and each such committee must be created, and shall have and may exercise such power and authority of the Board as shall be specified for it by vote of the greater of: (i) Trustees constituting a majority of the entire number of Directors in office at the time; or (ii) the number of Trustees required to take action under the Bylaws or the Certificate of Incorporation if either such document requires a vote greater than a majority of the entire number of Trustee in office at the time. A committee which is so created and appointed by the Board shall be referred to as a "Committee of the Board".

(b) Notwithstanding the foregoing, Committees of the Board may not: (i) fill vacancies on the Board or any of its committees; (ii) amend the Certificate of Incorporation; (iii) adopt, amend or repeal Bylaws; (iv) approve a plan of merger; (v) approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation, other than a mortgage, pledge or other encumbrance described in subdivision (2) of subsection (a) of section 33-1165 of the Nonstock Act; or (vi) approve a proposal to dissolve.

6.2 Additional Committees.

(a) In addition to Committees of the Board, the Corporation may have standing committees and such other committees as may be created by resolution of the Board. The standing committees and other committees may consist of Trustees, or of both Trustees and non-Trustees, provided that these shall be at least two Trustees appointed to each committee. Members of all committees shall be appointed annually by the Chairman and approved by the Board. The Chairman shall designate a Chairman and Vice-Chairman of each committee. Committee Chairmen, and in their absence the Committee Vice-Chairmen, shall conduct all committee meetings.

(b) No committee other than a Committee of the Board shall have or exercise any power or authority of the Board. A committee which is not a Committee of the Board may advise, recommend, investigate and report to the Board and/or to the officers of the Corporation on such matters as may be assigned to it, but shall not exercise the power or authority of the Board.

6.3 Standing Committees. The standing committees of the Foundation shall be the Governance and Nominating Committee, the Investment Committee, the Development Committee and the Audit Committee. Where these Bylaws prescribe a minimum number of Trustees to be appointed to a standing committee, the Chairman, as an *ex-officio* member of all committees, shall not be counted for the purpose of meeting such requirement.

6.4 Governance and Nominating Committee. There shall be a Governance and Nominating Committee consisting of no greater than **[eight (8)]** and not less than [three (3)] individuals chosen from among the Board and the Advisory Council and past Chairmen of the Foundation. Consideration for membership on the Committee shall be given to past Chairmen of the Foundation. The Governance and Nominating Committee will meet on an as needed basis at the direction of the Chairman, but will meet at least three (3) times per year, to include planning meetings in March and June, and one or two meetings in the fall, in order to make its nominations available to the Board by its regular meeting in **[May]**. The Governance and Nominating Committee is responsible for making recommendations to the Board on issues related to the size, structure, duties and effectiveness of the Board, making nominations to the Board and Advisory Council, and such other duties as may be provided in the Nomination Committee Charter approved by the Board from time to time and as otherwise assigned from time to time by the Chairman or the Board.

6.5 Investment Committee. There shall be an Investment Committee consisting of no less than five (5) members. The Investment Committee shall oversee investable funds of the Foundation and shall be charged with the supervision of the investment advisors so engaged by Foundation to manage and invest such funds under the investment guidelines and objectives which have been ratified by the Board. The Investment Committee shall also be charged with examining and recommending options for the handling of the Foundation's terminated pension plan. The Committee shall meet on a quarterly basis and report its activities to the full Board at its next regularly scheduled meeting. The Investment Committee's responsibilities shall also include those set forth on the Investment Committee Charter approved by the Board from time to time. Any changes to the Investment Committee Charter shall require approval of the Board.

6.6 Development Committee. There shall be a Development Committee of no less than **[three (3)]** members. The Development Committee shall oversee matters related to charitable resource development of the Foundation. The Development Committee's responsibilities shall also include those set forth on the Development Committee Charter approved by the Board from time to time. Any changes to the Development Committee Charter shall require approval of the Board.

6.7 Audit Committee. There shall be an Audit Committee consisting of **[three (3)]** members. **[Two (2)]** individuals shall be Trustees; all members of the Audit Committee shall have sufficient financial literacy to carry at the duties of the Audit Committee and shall be independent of the management of the Foundation, its affiliates, subsidiaries and the Post Closing Hospital and free of any relationship that in the opinion of the Board would interfere with their judgment as a committee member. Two members of this Audit Committee shall constitute a quorum, and the vote of the majority of members present shall be the act of the Audit Committee.

(a) The Audit Committee shall meet a minimum of three (3) times each year, and at the call of its chairman or the President. Audit Committee meetings may also be called by any two (2) members of the Audit Committee.

(b) The Audit Committee shall make or cause to be made such examinations of the financial affairs of the Foundation and its affiliates and subsidiaries (other than the Post

Closing Hospital) as shall be sufficient, in the opinion of the Audit Committee, to determine whether the financial condition of the Foundation and its affiliates and subsidiaries (other than the Post Closing Hospital) is sound, their practices correct, and the financial information furnished by their respective officers correct and compliant with applicable reporting requirements. The Audit Committee shall study each report on the Foundation conducted by the outside auditors, if any, and may consult directly with such auditors. The Audit Committee annually shall recommend to the Board an independent audit firm for the Foundation.

(c) The Audit Committee shall keep minutes of its meetings, and such minutes shall be submitted at the next regular meeting of the Board and any action taken by the Board with respect thereto shall be entered in the minutes of the Board.

(d) The Audit Committee's responsibilities shall also include those set forth on the Audit Committee Charter approved by the Board from time to time. Any changes to the Audit Committee Charter shall require approval of the Board.

(e) The Audit Committee shall develop, monitor and make recommendations to the Board with respect to financial reporting and compliance for the Foundation, including an appropriate educational component and audit procedures so that Trustees, senior management and staff of the Foundation are familiar with financial reporting and compliance.

ARTICLE VII
Miscellaneous

7.1 Seal. The seal of the Foundation shall be in such form as may be adopted by the Board.

7.2 Fiscal Year. The fiscal year of the Foundation shall end on September 30 of each year.

7.3 Conflict of Interest Policy. The Board shall adopt from time to time a conflict of interest policy.

ARTICLE VIII
Amendments

These Bylaws may be altered, amended or repealed at a meeting of the Board by the affirmative vote of two-thirds (2/3) if the notice for the meeting gave notice of and included the text of the proposed change; provided, however, that no amendment shall be effective that changes a quorum or voting requirement shall require such greater vote as may be required by the Nonstock Act.

EXHIBIT Q11-1: CHARITABLE GIFT ANALYSIS

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Not Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Charles F. Brooker Will and Codicil		$179,256	"in trust for the following purposes to wit: To be invested in the manner prescribed by law for trust funds, said fund to be known as the "CHARLES F. BROOKER FUND" and held in trust as a permanent fund, and the income therefrom to be used for the expenses and carrying on of the purposes of said Hospital. "I request said WATERBURY HOSPITAL of Waterbury in their respective use of the income from the aforesaid trust funds to give the preference to employees of the American Brass Company and its successors …	None	Y	N	N	N	Will being sent by Derby Probate Court
Clara A. Forester (Richard A. Forester Memorial Fund) 5/15/1956		$85,277	"the principal to be held by it in a perpetual trust to be known as 'The Richard A. Forester Memorial Fund' and the income only thereof to be used for the general purposes of said organization."	None	Y	N	N	N	Yes Trust u/w
Karl & Margaret Hallden Memorial Fund 7/25/1967	Bank of America, Agent	$101,083	principal distributed from Memorial Fund 6/1/1986 – consent to distribution in file	None	Y	N	N	N	Yes Will, Consent to Distribution and 12/20/85 letter from Colonial Bank detailing provisions of gift, Agreement between Waterbury Hospital and Colonial Bank

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Not Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
George R. Lamb (George B. Lamb and Harriet Welton Lamb Endowment Fund) 7/12/1923		$292,587	"the principal of said fund to be kept intact . . . and only the income therefrom used as the Board of Directors may determine for promoting and maintaining the Hospital and its work" "income therefrom used as the Board of Trustees may determine for promoting and maintaining the Hospital and its work"	"If for any reason said Waterbury Hospital shall fail or refuse to accept said fund upon the conditions above stated, the Trustee shall . . . set over all of the . . . assets belonging to the Trust Fund to such person . . . as shall have been designated by me in my last will and testament . . . ."	Y	N	N	N	Extract from Trust and Trust Agreement between Waterbury Hospital and Colonial Bank Trustee dated 1967

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Hattie/Harriet Schlegel Anderson May, 1986 July 21, 1986		$122,672	"income therefrom to be used to provide for the ongoing education of nurses at the Hospital through in-service programs, outside speakers, conference fees and expenses, tuition assistance in obtaining advanced degrees, or for other employees to become Registered Nurses, and books periodicals and other educational support systems"	None	Y	N	Y	N	Proposed language re distribution, and Custodial Agreement
At Risk Kids 1999		$1,040	Income will be used to "underwrite operations, after grant income has been exhausted, for programs that focus on preventive strategies designed to decrease serious emotional and behavioral problems."	None	Y	N	Y	Y	Yes Resolution
Theodore Bevans 10/16/1963		$8,759	"used for the benefit of children hospitalized in the Waterbury Hospital."	None	N	Y	Y	N	Yes Contribution letter
Edith M. Chase (Henry Sabin Chase Memorial Fund) 1/24/1972	The Waterbury Hospital	$813,117	"to establish and maintain a dispensary under the name, 'The Henry Sabin Chase Memorial Dispensary."	None	Y	N	Y	N	Yes Will
Mildred Crozier 12/28/1988	The Waterbury Hospital	$289,435	"the income of the Fund, and such amount of the net appreciation (realized and unrealized) thereof…be used…to provide scholarship assistance to children of Hospital employees so as to enable them to pursue their professional education in medicine and related fields of caring." "…it is my desire that no part of the value of any contribution made by me…be so expended"	None	Y	N	Y	Y	Yes Instrument of Gift

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Marguerite B. Fulling 3/21/66 6/19/96		$78,961	"to be known as the Marguerite B. Fulling Research Fund, only the income from which is to be used for research of breast cancer".	Unknown – trust document not located	Y	N	Y	N	Gift letter and Waterbury Hospital Receipt & Release
Grad Nurse 1/30/1979		$7,359	To provide loans to graduate nurses for further education	None	Y	N	Y	Y	Yes Memorandum
Junior League Fund 2/1937 (memo from The Colonial Trust Co.)	The Waterbury Hospital	$2,199	"condition of gift: To be used as a special Medical Fund." – memo from The Colonial Trust Company "Amount of Gift - $1,500.00"	None	Y	N	Y	N	Yes Instrument of Gift
Sarann B. Kazanjian (Sarann B. Kazanjian Memorial Fund) 10/17/1974	The Waterbury Hospital	$72,495	"Fifty Thousand Dollars ($50,000.00) to The Waterbury Hospital,…and that the income from it be used to purchase equipment for medical and surgical purposes." ——— "If any of the principal or net income of the Residuary Trust shall remain undisposed of after compliance with all of the foregoing provisions of this Article VI, I direct my then Trustees to pay, transfer and deliver said undistributed portion to The Waterbury Hospital, to be to it absolutely."	None ——— None	Y ——— N	N ——— Y	Y ——— N	N ——— N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule A. Waterbury Hospital, Trustee – Use Restricted

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Sarann B. Kazanjian (Sarann B. Kazanjian Student Nurse Scholarship Fund) 8/12/1955 (citation to letter in unknown memo)	The Waterbury Hospital	$49,544	"$10,000.00 payable to the Waterbury Hospital… and the annual income therefrom be used to defray expenses of a student nurse or nurses during her or their period of nursing training. She further requests that preference be given to those student nurses residing in Waterbury and the surrounding towns of Naugatuck, Woodbury, Middlebury and Watertown…"	None	Y	N	Y	N	Yes Instrument of Gift – Student Nurse Scholarship Fund
LJ Mayo		$13,394	Scholarships for nursing students Gift in memory of Lewis Mayo, former pharmacist at Waterbury Hospital	None	N	Y	Y	Y	Yes Hospital Summary
Dr. M.H. Merriman 9/22/1964		$5,488	"to be established as a fund, the income of which is to be used to defray the expenses of personnel in the Waterbury Hospital Clinical and Pathological Laboratories in attending scientific meetings."	None	Y	N	Y	Y	Yes Draft Memorandum

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
Harriet/Hattie S. Anderson 9/21/1943	Bank of America	$89,126	"income to be used by said Waterbury Hospital Corporation to provide or assist in providing hospital care to deserving and needy residents of the City of Waterbury, Connecticut."	None	N	Y	Y	N	Yes Instrument of Gift
Mary Kingsbury Bull Fund (established by Edith Kingsbury) 1/24/1951	Bank of America	$22,988	"for the furnishing and providing an endowment of the Children's Ward in The Waterbury Hospital. When the furnishing is completed enough of the bonds are to be sold for payment to the Hospital and the balance to be carried in separate account with int. accruing against future withdrawal for replenishment."	None	N	Y	Y	N	Yes Record of Gift/Trust Agreement with Hospital
Almon B. Dayton 8/23/1940	Bank of America	$113,372 which is 6.67% of the total	"one-fifth of the net annual income of said trust shall be paid … annually in equal shares unto The Waterbury Hospital …, The Waterbury Anti-Tuberculosis League of Waterbury, Incorporated… and The Gaylord Farm Sanatorium…, in perpetuity."	"If any one or more of aforesaid religious and philanthropic organizations named as beneficiaries herein shall cease to exist or shall relinquish its corporate charter, or shall fail for any reason to function in the territory in which it is now located, its share of the income as hereinbefore determined shall be paid by my said trustee to The Waterbury Foundation Incorporated of Waterbury, Connecticut, to be used by the directors of said Foundation for religious or charitable purposes, preferably for some use similar to that performed by the corporation previously receiving said income."	N	Y	N	N	Yes Trust u/w
Natalie M. Dodd f/b/o Paul Heroux 5/18/76 9/13/84	J.P. Morgan & Co.	$0	"the balance of the remaining principal of the trust as follows: … 15% thereof to The Waterbury Hospital"	"In the event that an organization to which a portion or all of the remaining principal of the trust is directed to be paid…shall not be an exempt organization at the time of the Settlor's death, such portion…of the remaining principal of the trust shall	N	Y	N	N	Yes Amended and Restated Agreement and Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
				be paid, in the same proportions as aforementioned, to such of the aforementioned organizations as shall then be in existence and exempt organizations, or, if none of the aforementioned organizations shall then be in existence and an exempt organization, the same shall be paid only to such exempt organization or exempt organizations…as the Trustee, in its absolute discretion, shall determine."					
John Elton #2 for St. John's Parish 11/29/46 6/26/1947	Bank of America	$308,695 which is 50% of total	"net income. . . in equal shares, to St. John's Parish of the Protestant Episcopal Church . . . and to The Waterbury Hospital . . . to be to each of them absolutely."	None	N	Y	N	N	Yes Will and Codicil
J. Lincoln Fenn 10/23/1950	Stanhope Fenn Cunningham	$0	1 of 5 contingent remaindermen – Petition to Superior Court of California for transfer of trust to California was granted.	"…. To the Waterbury Hospital of Waterbury, Connecticut. I request that the shares of property that may be received by the above named institutions shall be added to their principal funds and kept safely, invested, and that only the income be used for the general purposes of said institutions respectively."	N	Y	N	N	Yes Trust u/w
I. Kent Fulton 10/02/1939 and 12/15/1939	Bank of America	$6,841,675	"To my trustee … I give and bequeath the sum of Twenty-five Thousand Dollars ($25,000), to be held by it in trust and the net income thereof to be paid over annually to the Waterbury Hospital… to be used by said Hospital for its general uses and purposes."	None	N	Y	N	N	Yes Trust u/w and Codicil
Donald F. Gibson 9/24/1983	JPMorgan Chase	$0	remainder beneficiary- approximate value $30,000	None	N	Y	N	N	Yes Trust u/w

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non- Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
Charles Hellmann (Sibilla Hellmann Fund) 6/13/1955	Bank of America	$10,428,750 which is 50% of total	"yearly income shall be divided equally between The Waterbury Hospital, Inc. and The St. Mary's Hospital Corporation . . . income to be used by each hospital as it may deem for the best interests of each hospital."	"In the event that either hospital goes out of existence, the entire net income shall be paid to the remaining hospital. If either hospital shall merge with another hospital and my Trustees believe that the corporation so formed carries out the purposes of the hospital so merged, then my Trustees shall pay one-half of the income to such amalgamated corporation, but, if my Trustees believe that the amalgamated corporation does not carry out the purposes of the hospital so merged and mentioned herein, then the entire income shall be paid to the remaining hospital. Should both hospitals mentioned herein cease to exist and there shall be no corporation or corporations formed as aforesaid so that there will be no charitable or eleemosynary corporation or corporations to which the income from the trust shall be paid, then my Trustees shall give the net income to the Meriden hospital, and, in the event that said hospital has ceased to exist or has not been amalgamated with any other charitable institution carrying out the ideals and principals of such institution, then my Trustees shall pay the net income in such proportion as they may deem advisable to other charitable, religious and eleemosynary corporations as shall be located in said Waterbury which carry out the principles and teachings of The Waterbury Hospital Inc. and The St. Mary's hospital corporation, and my Trustees shall have full discretion to designate the appropriate corporation or corporations and shall have full discretion as to the proportion of the net income which shall be paid to each corporation designated."	N	Y	N	N	Yes Trust u/w
Rhoda M. Hellman (Sibilla Hellman Fund) 11/11/1969	Bank of America	$5,369,352 which is 50% of total	"During the continuation of this trust the net income arising therefrom shall be divided equally between the Waterbury Hospital and St. Mary's Hospital, such payments to be made quarter-yearly or at such more frequent intervals as the Trustee shall deem wise."	"If either of the hospitals listed above is not an organization described in Sections 170(a), 2055(a) and 2522(a) of the Internal Revenue Code or has ceased to exist when income of the trust is to be distributed to it, the Trustee shall distribute all such income to the remaining hospital. If neither hospital shall qualify under such sections the Trustee shall distribute the income to such other organizations in the health care	N	Y	N	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non- Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
				field as are described in said Sections 1770(c), 2055(a) and 2522(a) as the Trustees shall select."					
Frank Keeling (The Frank Keeling Fund) 12/15/1954	Bank of America	$3,314,155	"income only thereof to be paid . . . to be used for the general purposes of said Hospital"	None	N	Y	N	N	Yes Trust u/w
Jacob Keeling (The Jacob Keeling Fund) 6/30/1952	Bank of America	$2,554,825	"income only thereof to be paid . . . to be used for the general purposes of said Hospital"	None	N	Y	N	N	Yes Trust u/w

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non- Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
Harriet Kirk 6/15/1942	JP Morgan Chase	$437,028 which is 20% of total	"one-tenth of the net income to The Waterbury Hospital, Inc., … the same to be used for the general purposes of the corporation."	"In the event that said corporation goes out of existence, then said income shall be divided equally among the other corporations and associations mentioned in Section B; but, if said corporation shall merge with any other corporation and my Trustee believes that the corporation so formed carries out the purposes of THE WATERBURY HOSPITAL, INC., then my Trustee shall pay the net income to such amalgamated corporation, but, if my Trustee believes that the amalgamated corporation does not carry out the purposes of THE WATERBURY HOSPITAL, INC., then the net income shall be divided equally among the other charitable and eleemosynary corporations and association mentioned in Section B. … Should all of the corporations mentioned in Sections A and B aforesaid cease to exist,… then my Trustee shall give the net income, in such proportion as it may deem advisable, to other charitable, religious and eleemosynary corporations as shall be located in Waterbury, which carry out the principles and teachings of the corporations hereinbefore mentioned…" Note: The corporations and association mentioned in Section B are Waterbury Day Nursery Association, The Southmayd Home, Inc., The Waterbury Visiting Nurses' Association, Inc. and The St. Mary's Hospital Corporation.	N	Y	N	N	Yes Trust u/w
Henry H. Peck 6/12/1918	Bank of America	$8,444,443	"Whereas, the Board of Directors of the Waterbury Hospital…has entered into a contract for the construction of an addition to the buildings of said hospital,…I direct my executor to pay over to the Treasurer of said Hospital such sum as may be determined by my executor and the Board of Directors of said Hospital to be necessary to pay the cost of said building.	None	N	Y	N	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule B. Third Party Trustee

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non- Endowment Y/N	Use Restricted Y/N	Solicited Under §21a-175 Y/N	Instrument of disposition in file Y/N
			... "pay over the net income semi-annually to the Waterbury Hospital...for general uses of said institution.						
Edith F. Poole 4/11/1928 (Francis A. and Florence A. Poole Fund)	Bank of America	$145,712 (50% of total)	"the net income thereof shall be divided equally, semi-annually, between the Second Congregational Church . . . and the Waterbury Hospital . . . the same to be used for the general purposes of said organizations."	None	N	Y	N	N	Yes Will
Wilma A. Snowden 10/25/1984 12/27/1990	Comerica Bank	$0	Contingent remainder interest	None	N	Y	N	N	Yes, Trust Agreement and Amendment
Kenneth J. Stoughton for Paul L. Baraby 6/13/1977	Bank of America	$0	"Upon the death of said Paul L. Baraby, the entire corpus of said Trust shall be distributed to The Waterbury Hospital...to be added to its equipment fund... 12/31 Value - $360,700	None	N	Y	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule C. Miscellaneous

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Gift Annuity April 3, 2003	Waterbury Hospital	$138,540	Gift annuity funds payable to Waterbury Hospital at donor's death	None	N	Y	N	Y	Board Resolution, Letter of Understanding and Investment Policy Statement
Molly Patricia Lenners 2/27/08 PENDING: Temporary Administrator appointed 10/16/14		Estimate $500,000	The remainder of my estate, or all of my residuary estate if Douglas L. Fox does not survive me, shall be distributed as follows: 1. One third to St. Mary's Hospital of Waterbury, Connecticut to be used for the care and treatment of mental illness; and 2. Two thirds to Waterbury Hospital of Waterbury, Connecticut		N	Y	N		Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Permanent Bed Fund Various Dates	Waterbury Hospital Trustee, Bank of America, Agent	$5,260,455	See Bed Fund documentation	See Bed Fund documentation	Y	N	Y	N	
Edith Blakesley Fund 03/08/1961	JPMorgan Chase $2,328,423.42 As of 9/30/15	$0	"net income to be used by Hospital as a free bed fund for members of the Second Congregational Church who are considered as worthy ill cases requiring financial assistance". Also used by other churches and for payments at St. Mary's Hospital	"In the event that said The Waterbury Hospital shall be merged into or taken over by another private nonprofit hospital the said Trustee shall make payment to the successor corporation. In the event that the said The Waterbury Hospital shall terminate its existence, the said Trustee shall have the power to send such income to such hospital operating in the City of Waterbury, or serving the public of the City of Waterbury, as it may, in its judgment , select."	N	Y	Y	N	Yes Trust u/w
Margery K. Hayden (Elizabeth K. Hayden Fund) 02/03/1975	The Waterbury Hospital	$35,368	"the sum of Twenty Thousand Dollars ($20,000) to be known as "The Elizabeth K. Hayden Fund", to establish a bed fund, the income from which shall be used for the purpose of providing free bed and medical care to patients of Southmayd Home, Incorporated, of said Waterbury, who shall be designated by the Board of Directors of said Southmayd Home, Incorporated, as being eligible to receive said free bed and medical care. In the event that all or any portion of said income in any consecutive twelve months period (said period to be determined by said Hospital, in its sole discretion) shall not be needed for the purpose of providing free bed and medical care, same may be used by said Hospital for its general purposes."	None	Y	N	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Merrit Heminway (Merrit Heminway Bed Fund) 1914 (extract from executive committee report)	Waterbury Hospital	$248,106	From Hospital Records: "Income to maintain bed for Watertown poor." Letter 10/31/60 from Katherine H. Heminway: "wish of his family that the income from this sum be added to that of the Merritt Heminway Bed Fund and administered as that fund has been administered in the past . . . . We wish that the word "poor" be interpreted to mean anyone whose hospital bills (not being otherwise fully covered) are such that the patient would be burdened thereby so that help in their payment might be considered of curative value. It is also our wish that any income from this fund left at the end of each hospital fiscal year be turned over to the hospital's general funds."	"The Board of the hospital should feel free to request the family of Merrit Heminway to change the above provisos if in their opinion the fund is no longer serving a useful purpose. If the time should arise when there were no family left to confer with, the interest and principal of the fund should be used in such a way as best to serve Watertown patients."	Y	N	Y	N	Instrument of Gift – Addition to Bed Fund

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Abbie C. Hopkins 4/30/1938	Bank of America	$5,939,804	"If, however, at the termination of said twenty-year period, no hospital has been built by the Naugatuck Hospital in said Naugatuck, I direct the Trustee to continue to hold and invest and reinvest said fund and the increment thereto, as aforesaid, until a hospital has been erected in said Naugatuck by the Naugatuck Hospital, and meantime to pay to The Waterbury Hospital…said remainder of the net income from said fund and from the increment thereto for the purpose of providing accommodations and medical care and attention for the poor and needy residents of the Borough of Naugatuck aforesaid, with the understanding, however, that the surplus of said income, if any, may be used by The Waterbury Hospital aforesaid for its general uses and purposes. (c) If, at some later period, a hospital is erected in said Naugatuck by the Naugatuck Hospital, I direct the Trustee to pay said remainder of the net income from said fund and from the increment thereto, in perpetuity, to the Naugatuck Hospital, to be used for the general purposes of said institution."	None	N	Y	Y	N	Yes Will
Mary L. Meigs (The Meigs Fund) 7/17/1952	The Waterbury Hospital	$1,243,892	"... the principal thereof to be held as a perpetual trust to be known as the "Meigs Fund", and the income only thereof to be used for the care at said hospital of persons in reduced circumstances in such manner as the Board of Directors of said Hospital may determine"	None	Y	N	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Edith F. Poole 4/11/1928 (Francis A. and Florence A. Poole Fund)	Waterbury Hospital	Part of Permanent Bed Fund	"($10,000), to the Waterbury Hospital…to be held as a permanent fund and invested and reinvested, and the net income thereof applied towards the establishment and maintenance of a free room in said hospital for the use of such person or persons as the minister in charge for the time being, of the Second Congregational Church, of Waterbury, Connecticut, may designate.	None	Y	N	Y	N	Yes Will
Scovill-Kingsbury Bed Fund 1915 (extract from Executive Committee Report)	Waterbury Hospital	$252,036	"extract from Report of Executive Committee 1915: 'endowing a free cot for the benefit of the poor of St. John's parish Waterbury'." - undated Waterbury Hospital record	None	Y	N	Y	N	Yes Acknowledgment of $5,000 gift by hospital
Flora S. Page and George W. Smith (Curtis Hurlbut Smith Bed Fund)	Waterbury Hospital	$199,434	"The Curtis Hurlbut Smith Endowed Bed has been added to our list. Mr. Smith, a native of Southbury, is thus memorialized by the generosity of a brother and sister."	None	Y	N	Y	N	Yes Hospital Summary

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
W. Easton Smith 5/31/44 (Howard Easton Smith Fund)	Bank of America	$129,635	"I give and bequeath to The Colonial Trust Company, of Waterbury, Connecticut, the sum of Five Thousand Dollars ($5,000.00), in trust, however, to hold, manage, invest and reinvest, and pay over the net income thereof semi-annually to the Waterbury Day Nursery Association, of said Waterbury, for its general purposes, said fund to be known as "The Howard Easton Smith Fund." "Should any of the corporations, institutions or organizations named as beneficiaries of the trust created by Paragraphs 8, 9 and 10 of this Will, dissolve, terminate or cease to carry on their corporate purposes, I direct that the income otherwise to be paid to such corporation, institution or organization shall thereafter be paid to The Waterbury Hospital, of said Waterbury, for its general purposes."	None	N	Y	N	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Ruth Sperry (Mr. and Mrs. Mark L. Sperry, Sr. Memorial Fund) Letter 12/3/1947 Letter 7/13/1976	The Waterbury Hospital	$197,525	"$2,500. to be used toward a hospital Bed Fund. .. 1. For employees and their families of the Scovill Mfg. Co. 2. For members of the Sperry family. 3. For such persons as I, or somebody that I might designate, might direct. I wish the unexpended balance in the fund to be carried over to the next year until the Fund reaches the sum of $10,000. After that it may be turned over to the Superintendent for general purposes of the institution." ——— "I give to the Waterbury Hospital...approximately $10,000 to be added to the Mark L. Sperry and Julia P. Sperry Bed Fund. The income to be used preferably for members of The First Congregational Church and employees of The Scovill Manufacturing Company or to anyone in need of hospital assistance."	None	Y ——— Y	N ——— N	Y ——— Y	N ——— N	See Bed Fund Binder
Dwight H. Terry And Martha Terry (The Dwight H. and Martha J. Terry Fund) 3/08/1919 11/21/1918	The Waterbury Hospital	$689,169	"only the proceeds thereof shall be used for the purpose of providing free beds and medical care and attention for the poor and needy of the Towns of Plymouth and Thomaston . . . and that the surplus of said income, if any, may be used for the general uses of said institution"	None	Y	N	Y	N	Yes Trust u/w Dwight Terry and Trust u/w Martha Terry
Olive Rogers Warner (The Richard Vincent Warner Memorial Fund) 4/22/1926	The Waterbury Hospital	$1,433,242	"as a trust fund . . . . only the proceeds thereof shall be used for the purpose of providing accommodations and medical care and attention for the residents of the Borough of Naugatuck . . . and that the surplus of said income, if any, may be used for the general uses of said institution"	None	Y	N	N	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule D. Permanent Bed Funds

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
Estate of Oscar L. Warner (The Warner Memorial Fund) 2/29/1932	Bank of America	$2,476,144	"the income thereof for the purposes of providing accommodations and medical care and attention for the poor and needy residents of the Borough of Naugatuck, Connecticut, with the understanding, however, that the surplus of such income, if any, may be used for the general purposes"	None	N	Y	Y	N	Yes Will

Trusts and Other Dispositions Benefiting Waterbury Hospital

Schedule E. General Endowment Fund / Not True Endowment / Board Designated

Name Date	Trustee	Value as of 7/31/15	Language of Disposition	Language of Succession	Endowment Y/N	Non-Endowment Y/N	Use Restricted Y/N	Solicited under §21a-175 Y/N	Instrument of disposition in file Y/N
General Endowment Fund	Waterbury Hospital	$1,914,232	Consists solely of outright gifts		N	Y	N	Y	

EXHIBIT Q11-2: CHARITABLE GIFT INSTRUMENTS (CD)

EXHIBIT Q12-1

ADDITIONAL OFFERS RECEIVED BY HOSPITAL

Allied Global Consulting Inc.

AGC

Dated 04/27/15

To
Mr. James Cain
The Cain Brothers.
360 Madison Avenue, 5th Floor
New York, NY 10017

Subject: Proposal to bid for Greater Waterbury Health Network .

Jim Hi,

Allied Global Consulting INC / Allied Assets INC is pleased to propose Joint Venture between GWHN - 20% and Allied Global Consulting 80%. 80% ownership of $35,000,000.00 which would be paid for by allied global consulting group with 80% ownership of GWHN asset and revenue base. In addition Allied Global consulting will Invest 80% of 55 Million for the capital improvements of the GWHN over next 7 Years. Allied Global Consulting INC / Allied Assets INC, was able to secure 100% funding of the proposed bid amount through M&T Bank.

Allied Global Consulting will be aligned with Quorom Health Resources to run the operations of the GWHN. Allied Global Consulting will be going under a minimum of 24 months to 48 months agreement to run the GWHN. The agreement between Allied Global Consulting and QHR will be finalized upon the completion of the joint venture deal.

Should you have any questions, please feel free to contact me. (Cell 714-875-1521)

Sincerely.

Syed Kazmi
Managing Director

(Electronic Signature)
Signed and Dated 07/14/14

EXHIBIT Q14-1

TRANSCRIPT OF INFORMAL HEARING REQUIRED BY CONN. GEN. STAT. §19a-486a(c)

PUBLIC HEARING

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

TOWN
Waterbury, Connecticut

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

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

PLACE
Courtyard by Marriott
63 Grand Street
Waterbury, Connecticut

BRANDON HUSEBY REPORTING & VIDEO
249 Pearl Street
Hartford, CT 06103
(860) 549-1850
(800) 852-4589
Reporter: Tiffany V. Pratt, LSR #00128

(Hearing commenced: 05:05 p.m.)

MR. CONTADINI: Welcome. I'd like to first off say my name is Carl Contadini. I'm Chairman of the Board of Greater Waterbury Health Network, and the goal of this evening's hearing is to provide our community with an overview of the transaction between Greater Waterbury Health Network, the parent organization of Waterbury Hospital, and Prospect Medical Holdings. This opportunity is to offer members of our community an opportunity to ask questions, offer comments in regards to the transaction that goes through the regulatory process.

The agenda for this evening is that following me will be Darlene Stromstad, President/CEO of Greater Waterbury Health Network, will provide an overview of Greater Waterbury Health Network today and plans for future growth and partnership. Dr. Carl Sherter, member of the Greater Waterbury Health Network Transaction Task Force, will share the medical staff involvement in the process. Ann Zucker, Greater Waterbury Health Network attorney at Carmody, Torrance, Sandak & Hennessey will describe the statutory requirements

for the hearing and conversion process and discuss the structure in terms of the transaction, and then we will open the floor to comments and questions. Dr. Mitchell Lew, President of Prospect Medical Holdings, and Tom Reardon, President of Prospect East, are here with us this evening to also answer questions.

Tonight's presentation and the questions-and-answer period will be recorded, transcribed and submitted to the state Department of Public Health, the Office of Health Care Access and the Office of the Attorney General. This hearing is a legal requirement for the state regulatory approval process.

For the question-and-answer comment portion of this evening, you must sign in if you wish to comment or ask questions. If you do not sign in -- if you have not signed in and wish to speak, please go to the registration desk to do so. If you have signed in to testify, I will call your name to come up to one of the microphones to make your statement or ask questions. Before you begin your testimony, please state your name and the town of residence. In order to give everyone who wishes a chance to speak, we request that each speaker

limit their participation to one appearance at the microphone and limit your comments to no more than three minutes. Your statements or comments should be directed to the contents of the letter of determination.

Copies of the letter of determination are available this evening for your review. They're on the table outside the door. The letter of determination may also be found on the attorney general's website along with other filings for this regulatory approval process and will be available on site of the Office of Health Care Access website as the process advances.

Before we begin this evening's presentation, we've asked the mayor of this great city of Waterbury to say a few remarks. We welcome Mayor O'Leary.

MAYOR O'LEARY: Good evening everyone. Thank you Carl, Darlene. I am Neil O'Leary. I'm the mayor of the City of Waterbury. I'm here this evening to express my strong support for the proposed transaction between Waterbury Hospital, Greater Waterbury Health Network and Prospect Medical Holdings.

First, let me state the obvious. Here

we are once again discussing the future of the health care system in our region. I am confident that with this transaction we can finally move forward. The reason I say this is despite the disappointments of the recent past, I believe this is Waterbury Hospital and Greater Waterbury Health Network's moment. We will take the next step in building a world class health care system.

Tonight we will hear Waterbury Hospital and Prospect Medical Holdings, and most importantly we will hear from this community, but I hope to make a point to the regulators who will ultimately have to approve this transaction, when they review the transcript from this evening, I hope they will understand that these are far more than words that they are reviewing. These are lives, the lives of the residents of this region, the fundamental health care opportunities that all, including those who most desperately need access, can be assured of.

This transaction is about the future incredible professions in the Waterbury Hospital Network who dedicate themselves every day to us, our families, friends and neighbors. This is not only about the stability of their jobs, but the economic viability of this entire region.

Our city and region are on the cusp of resurgence. This application we speak of tonight is a vital building block in that resurgence, and I am entirely confident that this transaction is the right path for health care in Waterbury.

It is very clear that the health care environment is significantly and rapidly changing. There is no going back. The leadership of Waterbury Hospital and Greater Waterbury Health Network anticipated these major shifts in health care and have been working to establish a partnership with a strong capital partner to ensure the sustainability of health care services for our community.

For the last 125 years Waterbury Hospital has been growing and adapting to meet the community's dynamic health care needs, and I have no doubts whatsoever that they will continue to do so.

The hospital is a vital community asset. It provides health and medical care, of course, but it also conducts outreach and education in the community. It educates the future health care and medical workforce and its regional economic engine with 2,000 employees. It is clearly an essential resource and asset for the city in the greater Waterbury region.

I recently met with representatives of Prospect Medical Holdings to learn more about the company and the benefits it could bring to Waterbury Hospital, Greater Waterbury Health Network and this community. I was very, very pleased and very impressed with their innovative model and what they have been accomplishing in California, Texas, and Rhode Island. I know we will hear more about that in detail this evening, and I'm excited. It is what Waterbury and this entire region desperately needs. We deserve no less than a leading edge, world class health care system.

Yes, they will invest capital to update areas of Waterbury Hospital, but they will also be investing in expanding access to health care throughout this community that is bringing health care and resources to people where they live.

The overriding goal of Prospect's health care model is to improve the health of the community through more effective management and coordination of population health. This involves more than just the hospital, but the entire health care system and local community resources. This is the new era of health care, and Prospect has demonstrated with its regional coordinated care

model that it can both improve the community's health while controlling costs.

I'm excited by the opportunities, resources and expertise that Prospect brings to our region.

I am supporting the acquisition of the Greater Waterbury Health Network by Prospect Medical Holdings because it will strengthen health care services for our community both today and for generations to come.

You know, we have been down this road, as I mentioned earlier. When I was elected and started office in December 2011, I never expected to endure the peaks and valleys of this process starting with LHP and Tenet, but I am confident and I really am standing here in complete confidence having spent significant amount of time with Prospect and talking at length with Darlene and her staff that the people, the staff, the fine staff, committed staff at Waterbury Hospital really believe this is it. I'm also confident that the officials in Hartford believe this is it.

I'm a little scared, little anxious. Father, pray for me, please. But I really am excited. I had a great feeling after meeting

Tom Reardon the first few minutes and several conversations, and, you know, Kevin and I have done an incredible amount of research on Prospect, and I'm not a hospital administrator, nor am I a doctor, but I am the leader of a community that has been through too many peaks and valleys, and this is our time, and we need to send a message clearly to the state and for all those that are in this reviewing process that we're comfortable, and I believe we are comfortable. It's been a long, arduous road, but I truly believe from the bottom of my heart that we finally got -- that we're here. We just have to keep it going and get it done.

So I really do appreciate the opportunity to speak with you all here tonight. I've got this horrendous schedule, and I've got to get back to where I came from, but I just really felt that it was so important for me to be here with you tonight and let you know how we feel together, collaborating, working together for the right, and the right here is this acquisition. Thank you all.

MR. CONTADINI: Thank you, Mayor O'Leary.

To continue in our presentation this evening, what I would like to first do is to go over

the organizations that are included in the Greater Waterbury Health Network. In that network is Waterbury Hospital, VNA Health at Home, Greater Waterbury Management Resources, Greater Waterbury Health Services, Alliance Medical Group, Cardiology Associates of Greater Waterbury, Access Rehab Centers, Imaging Partners, Waterbury Gastroenterological Co-Management, Harold Leever Cancer Center, Heart Center of Greater Waterbury, Valley Imaging.

We are proposing that this network be acquired by Prospect Medical Holdings, a privately owned company that provides health care services in Rhode Island, Texas and California. This means that we will substantially sell all of Greater Waterbury Health Network's assets to Prospect Medical Holdings. Ann Zucker, Greater Waterbury Health Network's attorney, will provide the detail about the transaction in a little while.

As you know, as the mayor just said, this is not our first time down this road. Greater Waterbury Health Network, Waterbury Hospital has gone through this regulatory process for a proposed partnership. We don't plan to spend much time this evening rehashing those processes. There was

certainly a great deal of information available through the last few years. Tonight is about looking forward to the future of health care in this region.

A great deal has happened in five years since Greater Waterbury Health Network Board of Directors determined that a strategic capital partner was necessary to ensure the sustainability of our network and hospital, while we still believe this is the true path forward, particularly in a rapidly changing environment we are operating in.

The significant changes we anticipate in the health care industry are five years ago, in the future, today; they are upon us. And we're not talking about incremental change. We are talking about monumental change that is very rapid. For Waterbury Hospital and our network, this has meant significant challenges, but also tremendous opportunities, and we believe that the proposed transaction with Prospect Medical Holdings is one of those opportunities. We will be hearing a great deal more about this throughout this evening.

The Greater Waterbury Health Network board's transaction task force that has been guiding our search and process for a strategic partner, our

goals for a partnership, included one that would enable us the likelihood of coming to a close on a transaction. This meant a more simple structure for the proposed partnership as well as a transaction that would be dependent only on our organization and our partner, a partner that would provide the capital to address the immediate needs while making a long-term commitment for strengthening and growing services to our community, one that offers the least disruptive to our services and employees, a partner that has experience in a new model of health care payment and delivery, not only for the hospital, but for all of the components of the network.

Directly after Tenet left the state of Connecticut, our investment bankers immediately looked at our options for a new partner. While some health care companies and organizations reached out to us, we again looked closely at the initial proposals that Prospect submitted to us over two years ago. Frankly, when we chose Vanguard as our partner in 2012, which was then acquired by Tenet, Prospect was also a top contender. However, we were concerned that Prospect didn't at that time have any hospitals in the northeast, but now they have two hospitals in Rhode Island and they're in the process

of acquiring a hospital in New Jersey.

The task force and the Greater Waterbury Health Network Board of Directors have conducted extensive due diligence on Prospect. Our physicians and leaders have visited Prospect headquarters in Los Angeles and hospitals in Rhode Island. Prospect representatives have met with our employees, medical staff, labor unions, elected representative, state leaders, payers, the mayor, our Greater Waterbury Health Network membership, and a whole host of others. The Greater Waterbury Health Network Board of Directors receives regular updates on the proposed partnership with Prospect.

Our extensive review and due diligence has demonstrated that Prospect Medical Holdings is the right partner not only for Greater Waterbury Health Network, but for all of our community.

Prospect offers innovative and proven models for delivering high quality care at low cost, has a track record of strengthening health care systems, not just the hospital, with the goal of providing high quality care and a community care that provides the health and quality of lives of individuals and their families. This means

expanding access points within the community to make it easier for you and your families to see a doctor on a regular basis. As an example, in California Prospect arranged for pharmacists to visit patients's homes and to help make sure they're taking the correct medication and correct dosages. Prospect also can coordinate transportation for people to ensure they make up their follow-up appointments. Additionally, in an effort to break down barriers to good health, they provide translators to assist patients in assessing health care services. They will also address our immediate capital needs while committing to a long-term investment in health care services. In their short time in Rhode Island, Prospect has expanded Charter Care Physicians Network, expanded ventures for an outpatient oncology center and invested over 10 million in strategic capital purchases.

Prospect has experience with stringent regulatory environments given their recent acquisition in Rhode Island which increases the likelihood of closing a transaction here in Connecticut with its regulatory environment.

We are excited about the opportunity of our network to become part of Prospect. This

represents the future of health care. Their approach to coordinated care for patients, population management is making a difference to thousands of people in the communities they serve.

Before we turn to the details of the transaction, I'd like to have Darlene Stromstad, President and CEO of the Greater Waterbury Health Network, talk about what is happening at Greater Waterbury Health Network. Darlene.

MS. STROMSTAD: Thank you, Carl. And, you know, I feel like after the Mayor's speech, all the rest -- spoke to us, that all the rest of us really don't have much to say, because I think his message was so great and he nailed it.

I look around the room and I see a lot of familiar faces here, and many of you have been on a long, long journey with us, and I want to thank you for your continued support, but I want to bring us back to why we're really here today and why a strategic partner is necessary for the Greater Waterbury Health Network.

First, we need to still have access to capital and afford investments in our organization. We need to improve our financial condition and reduce or eliminate our debt. We want to

participate in new payment systems and delivery systems, and a partnership with Prospect will allow us to do that. We also want to protect, preserve and grow local asset -- access, sorry, to services.

Our industry is quite simply changing rapidly. We are moving from a fee for service to a pay for quality outcomes. Basically, what this means is that our payment source is turning 180 degrees which requires that we have systems and structures in place to respond to this changing industry. An organization like Waterbury simply cannot do this alone, but with the resources, the experience and the knowledge of a company like Prospect, not only can we join the future, we can become a leader in the way health care is delivered in the state of Connecticut in the future.

There continue to be challenges in the financial reimbursement of health care. We see continued payment erosion from the federal government through Medicare, declining levels of payment from the state, Medicaid. The payment reforms are putting more financial risk on the providers. We will continue to have pension obligations that we will honor, and we are facing, like many other businesses, with rising costs. All

of these factors mean that it's harder and harder for us to have the resources to invest in the future of our organization.

As you know, in 2010, the board of Greater Waterbury Health Network made the farsighted and right-sighted decision to find a capital partner for our organization. They were kind of ahead of their time. And since then you know what's happened because you've been on the journey with us to the disappointing end of our transaction this January.

At that time our organization made the very concrete decision that we were going to operate on two paths. One, we were going to do everything we possibly could to strengthen and expand the services of Waterbury Hospital and of the network with our limited resources and that we would also work to secure a strategic capital partner to ensure the long-term sustainability of our organization.

Whether alone or with Prospect, this is an organization that has long honored our focus on keeping our promise to our patients. We've done that in the past; we are doing that in the present; and we will do that in the future; our promise to our patients that they will stay at the center of everything we do in spite of any distractions, in

spite of any distractions, and we have had many.

Every week, every week I hear from patients who reach out voluntarily to tell me about the difference we've made either at their stay in the hospital or with a family member. So our -- what the mayor said about us being very meaningful on a real personal level to the people of this community, that is real, and we see it demonstrated every day.

We will continue, as we have in the past, to make quality and safety the foundation of the way we organize our work. And I am very proud that just last week we were selected by US News and World Report for being a best regional hospital.

We also have tried to keep up with some investments in our organization and recently brought on the XI robot, which is the newest generation of robot available. We've invested by replacing our CAT scan and C-arm. We're doing navigational spine surgery, which is new for our organization, and we are also using ultrasound-guided pain blocks with orthopedic patients who are having a lot better recovery time because of the less pain. We're doing what we can, but there's still so much more to get done.

We have remained and will continue to remain dedicated to providing education and training and making sure that we are reaching out and ensuring that there are the next generation of caregivers, whether that's through our residency programs or working with local colleges to help prepare nurses to come to work in our organization. PA's, respiratory therapists, pharm d's are coming through, and I know I'm forgetting some of the other many health care providers that we teach and train.

One of the things that I am most proud of Waterbury Hospital is the role that we have played and will continue to play in advocating, advocating for those people who are most at risk. This is an organization that reaches out and identifies young people who are most at risk and help teach them and train them and get them prepared for their education. We work with their parents to make sure they, too, have the skills they need to become good citizens of Greater Waterbury.

As individuals we have many, many people that donate their time, their money to all sorts of organizations in this community. The community matters to us, and I think we matter to them.

With a partnership with the transaction with Prospect Medical Holdings, we believe that this will secure the future of care and access for a population that so deserves world class health care. We have an aligned vision, mission and values with Prospect. They have a strong reputation for being strong partners with the medical staff, which we'll hear about in a minute and we think is very, very important to this medical community. They have extensive risk management experience, a long history of population health management, and I think very importantly they have a track record of competing successfully against large for-profit and nonprofit health care systems.

And the development of our relationship with Prospect begins now. We are talking about value-based contracts, and we are presently organizing an IP, an independent physician association network.

I think that the folks from Prospect who have spent much time with our organization see what I see and what our organization sees, and that's while there's much to be done, there is much opportunity ahead of us.

Dr. Carl Sherter, would you please come

and share your thoughts with us?

MR. SHERTER: Good afternoon, good evening. I'll try not to be repetitious. I did dress like the mayor. We got the memo. My name is Carl Sherter. I'm the recent chief of staff of the hospital. I'm an original member of the task force that examined the hospital's opportunities with various capital partners. I'm a practicing pulmonary critical care physician. I'm in private practice and an attending physician at both Waterbury and Saint Mary's Hospitals.

I'm most proud of that I'm the chairman of the state of Connecticut's Medicaid, Pharmacy and Therapeutics Committee. I've served as a volunteer since the inception of this committee. I helped write its bylaws and have chaired every meeting for the last 12-plus years. This committee has saved the state tens of millions of dollars, provided the most liberal lists of medication to Medicaid patients. I understand delivery of quality health care to the underinsured. These are our most vulnerable patients.

Over the four years we've looked for a capital partner, health care has changed, and we have changed our goals, and this is good. Under the

Affordable Care Act, health systems will attempt to keep patients healthy and keep them out of the hospital, a good thing. This will require a robust system of care, data driven with ancillary services that provide the best care available to every patient. Every health care system is starting to build this model. Our chosen partner, Prospect, has the system in place and has a proven success with the system in multiple states, as you've heard. We'll be up and running in months, not years, and that's very very important to this city.

Part of my due diligence was to visit two hospital systems in Rhode Island that Prospect acquired about a year ago. We met with their board president, their CEO, the chief nursing officer and six physicians who practice within the system. One physician was in private practice. The others are voluntarily employed. And this is important to the physicians. We got to spend nearly two hours with this group, and it wasn't limited. We spent as much time until we ran out of questions, and there were lots of questions. They said the best way to sum up their experience with Prospect was that Prospect was real and delivered all that they promised. Okay, I'm simplifying that, but it was true. They said

the patients are happy and get much better care than the old way of practicing medicine.

In Rhode Island, Prospect is eagerly taking on the Medicaid population. Hundreds of physicians have signed up on the first year. They like the new model that Prospect offers.

This venture will be good for the proud city of Waterbury. Our population is older than most other cities in Connecticut. The poverty rate is 20.6 percent. Unemployment is 13.1 percent. This venture, as the mayor said, will help stabilize our city and help our city move into the next phase of its existence. This is my editorial, maybe a city of health care and education. I like that thought.

Waterbury has provided excellent care to this community, it's been mentioned. I am proud of the over 1,000 physicians we have trained, many still in our city and in our area. I'm proud of the nurses, certified aids, respiratory therapists, physicians' assistants and pharmacists and probably more that we've trained. I'm proud of the staff of the hospital earning numerous awards for quality health care in spite of the hospital's financial constraints. You can not believe how proud we are

when we get one of these awards, not because it's ego, but because we know we're doing the job we ought to do. This is very important to the physicians and the staff of the Waterbury Hospital, a very friendly staff that all get along very well. We call it "the big group."

As I stated, for the last four years I've represented the staff of Waterbury Hospital and the patients that this hospital serves in its attempt to find a capital partner. I've been at every meeting. Prospect has met numerous times with the physicians who practice in Waterbury. The physicians have asked every question and gotten honest answers. They support this venture.

After almost 40 years of practice in Waterbury, I've seen its problems as a stand-alone hospital. We have an average age of physicians of 59 years. It's getting increasingly difficult to bring young health care workers to Waterbury. They want a secure future for their practice. They want modern equipment to diagnose and treat their patients. They want a stable future with a capital partner that will help with the economy of scale. They know the health care model has changed. They want to hit the field running with a proven system

that Prospect offers.

The people of Waterbury want health care in their own city, and this is important. This is a city of community and family values. Families support each other. Many of my patients come to my office with family members. They all ask, Is it going to happen? We answer, We all hope so. We need a capital partner to make this happen, and Prospect will be an excellent choice. Thank you.

MS. ZUCKER: Good morning. My name is Ann Zucker. I'm the hospital's lawyer, and I'm going to lead you through some very thrilling statutory requirements about our process and then tell you at a high level about the structure of our transaction, our post conversion foundation and where we're going and how long it's going to take, we hope.

So every time that a for-profit entity comes into the state and wants to take one of our nonprofit hospitals and make it a for-profit entity, the attorney general's office and the Department of Health division of Office of Health Care Access get involved. This is called a "conversion process." And these two agencies review the statutes and our applications concurrently, so they run along

parallel tracks.

So we've already filed our request for determination, and this is the next part of the process, that is, our public hearing. So you're at the very beginning of our process with us. So within 30 days after we filed our request for determination, we're holding the public hearing. It's being transcribed and will be available to our regulators and to the public, as Carl Contadini had mentioned.

We expect that the regulators will determine that this is a conversion process, that they will issue an application fairly shortly.

So the request for a determination -- I know that Carl covered this information earlier, but it is really the focus of our hearing tonight -- is a description of the buyer and the seller, a description of the transaction, which as you've heard is an asset purchase of substantially all of the assets of the network and its affiliates and subsidiaries. The cost of the transaction is $100,000,000, and we'll talk a little bit more about what that's comprised of, but most importantly, there are no changes planned to either our service area or to the services that will be offered.

Carl mentioned that we have a list of subsidiaries and affiliates that are going to be acquired, that is, that Prospect will step into the shoes of the Waterbury Hospital entity. You'll note that one entity that's not on here is our child care center. That's a very beloved entity, and that will not be part of this transaction. It will continue to operate, though.

So our partner in this transaction is Prospect Medical Holdings. We have some of the representatives here with us today. They're based in Los Angeles, California. They consider themselves a health care services company, not an owner of hospitals. They have a much broader view of themselves and their role. They do have 13 acute care hospitals in Rhode Island, Texas and California. They're in the midst of an acquisition process in New Jersey, and the last two nights they were up in the eastern part of the state because they have letters of determination pending with respect to the Eastern Connecticut Health Network hospitals, Rockville and Manchester hospitals. They have about 9,000 physicians affiliated with them, and it's a very physician-centric organization.

So moving on a little bit about what

our process is like, we do expect that the regulators will consider this a conversion; they will issue us an application. The application process is very, very thorough, very deep. There were literally thousands and thousands of pages filed. There were public hearings. It's a very transparent process, and the regulators have been very committed to making information about the process available to the public.

The application will go into depth about the identity of each of the applicants. It will talk about the diligence process of our board in reviewing Prospect and Prospect's diligence of us as well. We will have a fairness opinion by the entity that gave us fairness opinions in the past. We expect a favorable opinion on the fair market value of the transaction will be issued relatively shortly.

The application will also discuss the terms of the transaction. It will include copies of all of the transaction documents, for example, the Asset Purchase Agreement, which is the primary document. And it will also detail the plans of the foundation that will hold our charitable assets after the closing.

So the standards that the attorney general will look at are outlined in the statute. So, remember, he's looking at the statute along a parallel track with the Office of Health Care Access. So the attorney general must deny an application if the transaction is prohibited by Connecticut statutory or common law that deals with nonprofit entities, trusts or charities. He must deny it if the nonprofit hospital fails to exercise due diligence in either deciding to transfer, selecting the purchaser, obtaining the fairness evaluation or fairness opinion, and negotiating the terms and conditions of the transfer. He must also deny it if the hospital fails to disclose any conflict of interest and if it believes that the hospital will not obtain fair market value for its assets.

Other factors that he considers is whether the fair market value is manipulated to cause the value to be decreased, whether the financing of the transaction will put the hospital's assets at risk; if there turns out to be a management agreement, whether that management agreement is at fair market value. And then finally he looks at the foundation aspects, whether the fair

market value is being transferred to an appropriate entity. In our case that will be a foundation.

Then lastly, he has the ability to request pretty much any information they would like to see that's relevant, and so there's a requirement to fulfill those requests.

The Department of Public Health also conducts its process, and the statutory factors for that are whether the community will continue to have access to high quality and affordable medical care and that there's a commitment from the acquiring party that they will continue to provide care to the uninsured, the underinsured, and in the situation where insurers or providers have an opportunity to invest are some safeguards that must be in place to avoid any conflict of interest in patient referral.

So, finally, they also have the certificate of need conditions that are appropriate and apparent in each of those proceedings so that as public need, the continued access to health care, what the financial impact would be on the health care system across the state, whether the proposal will improve the quality of care, the accessibility and the cost effectiveness of the health care delivery system in our region.

So this is what the process looks like laid out on a time line, and honestly, we're all the way over on the left. This is the first public hearing that you see. The chart shows it will then get an application. We have 60 days to respond. The regulators have an opportunity to ask additional questions, and that could go several rounds. Ultimately, they will deem the application complete, and there will be public hearings and perhaps some additional interrogatories or additional questions.

And, finally, the regulators will issue a decision. They will either accept it as proposed, accept it with conditions, which is what happened last time, or deny the application.

So that's what the regulatory process looks like, and it's a long, hard road, and we welcome your assistance in our journey just as you gave it last time.

So this transaction is an asset purchase transaction. It's not a joint venture as we had in the Tenet transaction. It will, of course, include the continued operation of the hospital. There will be an advisory board that includes members of our community. Prospect has committed capital to improve the facilities and

equipment as well as to recruit new physicians to our community, to Dr. Sherter's point that we need to continue to be able to recruit younger, strong physicians into our community. Prospect has agreed to hire all of our employees and to assume our contracts, and they've committed to continue charity care and adopt the charity care policies that we have in place today.

Very briefly, the transaction overview: The assets that are included are the assets that comprise most of our health care giving assets, so that is the hospital, the physician practices, the interest in the joint ventures, for example, the imaging ventures, the heart center, the cancer center.

Excluded from the transaction are donor restricted funds, cash and investments. Our cost report settlements we're keeping, the child care center, as I mentioned before, and our captive insurance company that deals with our professional liability claims.

We are receiving a cash purchase price of $45 million. We will need to use some of those funds to address our outstanding liabilities, for example, our indebtedness which is comprised of some

CHEFA, tax exempt bonds. We'll address the unfunded pension plan liabilities, our captive insurance liabilities for the medical malpractice claims. Workers' compensation claims will be covered. There's some asbestos liabilities that we'll be insuring, are covered as well. And there will be some transaction costs.

The other part of the $100,000,000 is the $55 million that Prospect has committed to capital, a capital commitment which will include some hard assets, but also the development of a network within the community and physician recruitment.

So finally, our net assets will go into a foundation. There will be a new entry created that will hold our charitable assets, and we'll be able to provide some grants and so forth for health care needs in the future. We will ask for some representatives from the community to serve on this board and perhaps an advisory board as well. The foundation is anticipated to focus on community health needs, and it will be those directors of the entity that will manage and oversee the charitable assets that the attorney general makes sure that we are looking after.

And so I'll turn it back to Carl for the comment period.

MR. CONTADINI: Thank you, Ann. Thank you, Dr. Sherter for saying a few words here today. I think those were well done.

Before we start the question-answer period, as the mayor said, this has been a long road, and the road is not over yet, but I think with our working with Prospect, their determination to see this to the end, I think we're on that road right now to get to a finish line. And so to me that's very important. This is a hospital that's very important to me. I was born in this hospital. So to me this is the right thing to do.

So with that, and with Ann giving you a little bit in regards to the transaction, I'm going to get into the question-and-answer period. And I just want to remind, we want to make sure everybody can come up and talk. If you haven't signed up and you'd like to talk, you can go to the registration desk. I'm sure somebody's there to get your name on the list. And I encourage you to come up and talk. If there's something that's on your mind, it's important. This is a very transparent -- we're being very transparent here what's happening. We

have no hidden agendas, I can assure you of that. We're trying to preserve health care in this community for the next 100 plus years. That's what we're trying to do. So if there's something on your mind, please come up and talk.

So first on our list today is Paul Pernerewski, I'm hoping I'm pronouncing that right, President of Waterbury Board of Alderman. Paul.

MR. PERNEREWSKI: Thank you. Good evening. My name is Paul Pernerewski, and I am the president of the Waterbury Board of Aldermen.

I'm here this evening to express my support for this proposed transaction between Waterbury Hospital and Greater Waterbury Health Network and Prospect Medical Holdings.

Waterbury Hospital and its parent corporation, the Greater Waterbury Health Network, have been working very hard to identify and pursue the best strategies to ensure a sustainable hospital and health care network for our city and our region. One of the essential elements which has been identified is the need for a strong capital partner moving into the future. While there have clearly been obstacles and challenges along the way, the

proposed acquisition by Prospect Medical Holdings may be the right partner at the right time. Prospect brings a wealth of knowledge, information and expertise about how to thrive in the new era of health care. With their hospitals, physicians and health networks in Rhode Island, California and Texas and very soon in New Jersey, they are innovators and leaders in improving the health and quality of life for patients and communities, and they have demonstrated that they can strengthen care and outcomes while also holding costs in check.

Just as importantly, they have pledged to invest in our community. This transaction includes upgrades to Waterbury Hospital and to long-term growth and expansion in outpatient services which will help bring care closer to home for so very many in our region, and that investment is so very important to our continued development as a city both economically and as a community.

We're delighted that Prospect and the Greater Waterbury Health Network are working toward a partnership that will bolster health care for our city and surrounding communities and bring broad and lasting benefits for patients and community members.

I'm looking forward to the

opportunities ahead and urge the state regulatory agencies to help move this acquisition forward swiftly. Thank you.

MR. CONTADINI: Thank you, Paul. All right. Next, Dr. Jim Gatling, New Opportunities.

MR. GATLING: Good evening. My name is James Gatling. I'm the president of New Opportunities, and I'm also a member of the Greater Waterbury Health Network Board of Trustees. I, too, have seen this movie before, but this time it feels different. It feels right. It feels that Prospect is the right partner for us.

For those of you who aren't familiar with New Opportunities, I would like to take a few minutes, a few seconds to tell you about who we are.

We were formed in 1964 as the result of President Lyndon Baines Johnson's war on poverty. We are called the "Community Action Agency." We are one of 900 in this country. Our service area is Waterbury and the 27 surrounding towns. We have offices in -- we are headquartered in Waterbury, but we have offices in Meriden, Torrington, Thomaston and Danbury. We operate 50 different social service programs designed to eliminate poverty and help

those in need. Our services range from early childhood education to programs for the elderly. Also, a point of note, that our organization is the fourth largest employer in the city of Waterbury.

We understand the wide range of needs in our community, particularly those who are most vulnerable, low income and elderly residents, those who are medically frail, our children and those who have children. I have seen the vital role that health care plays in everyone's lives -- individuals, families, companies, the community as a whole. I believe that it is essential that every single individual in this community have access to high quality health care. It contributes not only to our health, but to the quality of life and the economy in this region. Let's remember, a healthy workforce is a productive workforce.

Waterbury Hospital has been fulfilling this role for the Greater Waterbury region. Our hospitals strive to provide access to quality health care for all, and we have been doing a tremendous job in spite of the challenges we have been facing over the last few years. Waterbury Hospital does much more than take care of people when they're sick. The hospital is woven into the fabric of the

community helping to improve the health and quality of life for our residents.

You will find Waterbury Hospital at virtually every community event, usually playing an active role in helping people access care, teaching them how to take care of their health. The rapid and accelerating change in today's health care environment makes it difficult, if not impossible, for stand-alone hospitals to survive. This is the situation with Waterbury Hospital.

We have known for years that the long-term sustainability of the hospital and the Greater Waterbury Health Network requires a strong strategic and capital partner, and we have been actively pursuing the right partnership for both our network and our community.

After learning about Prospect Medical Holdings' innovative approach to coordinating care for our community, I am convinced that this is the right partner for our hospital, our network and our community. Prospect brings a unique model, expertise and experience that will ensure that the community has expanded access to all health care services, not just hospital care.

I am strongly supporting the

acquisition of the Greater Waterbury Health Network by Prospect Medical Holdings because it will bring tremendous benefits to our community's health and quality of life. Thank you.

MR. CONTADINI: Thank you, Jim. Next Dr. David Pizzuto, Greater Waterbury Health Network.

DR. PIZZUTO: Good evening. My name is Dr. David Pizzuto. I'm the vice president of Medical Affairs and the Chief Medical Officer for Waterbury Hospital and the Greater Waterbury Health Network. I was born in Waterbury. I was raised in Wolcott and have been affiliated with Waterbury Hospital for 31 years, the last 28 as a practicing internist with a practice at 1211 West Main Street, in Waterbury.

During the course of my medical career I have witnessed many changes in health care, but nothing as dramatic as the changes occurring today. Currently hospitals, physicians and all segments of the health care environment are challenged as never before by the major shifts occurring in both health care delivery and health care payment. The overwhelming goals of these shifts are to improve quality of care, improve patient health care outcomes and to reduce health care costs.

I believe that Prospect Medical Holdings is the organization that can help Waterbury Hospital and our affiliates successfully navigate the changing seas of health care. Prospect has the experience to bring all facets of health care from physician practices to ancillary care to acute hospital care to care management together to effectively manage and coordinate health care for our patients and the people of the Greater Waterbury area.

Additionally, their innovative health care models offer the best possible care for today's complicated and complex patients. Over the last couple of months I have seen firsthand how Prospect delivers on its commitments to improve the health of patients while also controlling health care costs.

I was recently part of a group that went to the Rhode Island hospitals owned by Prospect as well as to Prospect's headquarters in California. We were all quite impressed with the investment, the innovation and the energy that Prospect brings to health care delivery and to health care payment.

We here in Waterbury have the opportunity to set the standard in this new era of health care with Prospect as our partner. We have

the ability to become leaders in population health management and coordinated care utilizing Prospect's resources, expertise and experience.

I believe that the acquisition of the Greater Waterbury Health Network by Prospect Medical Holdings will benefit the physician community, benefit the hospital and its affiliates, but most importantly, benefit our community, and I wholeheartedly support this transaction. Thank you.

MR. CONTADINI: Thank you, Dave. Next, Loraine Shea, Easter Seals.

MS. SHEA: Good evening. My name is Loraine Shea, and I am the president of Easter Seals of Greater Waterbury, a nonprofit organization serving the rehabilitation, education and employment needs of the community for over 55 years. I am also a resident of Naugatuck and a consumer of the Greater Waterbury Health Network services.

I would like to express my sincerest support for the proposed transaction between Prospect Medical Holdings and Greater Waterbury Health Network, the parent company of Waterbury Hospital.

Having spent the last 10 years of my professional career in various health care industry

roles in Waterbury, I have witnessed firsthand the challenges the health care industry has faced and the impact these have had on Waterbury Hospital. I am confident that Prospect's model of comprehensive regional care, its focus on growth of services and population management will serve the Greater Waterbury community well.

Prospect has demonstrated in its previous transactions that it is innovative, creative and forward thinking. It has also brought much needed capital resources to its partners, and this continues to be a significant need for Waterbury Hospital as we've already heard.

Prospect Medical Holdings will provide the stability, resources and investment and technology that is needed to continue to serve all the health care needs of the Greater Waterbury area.

Having worked alongside the employees of Waterbury Hospital, many of whom are here tonight, I feel I can confidently say that this transaction is strongly desired by those that take care of the patients that enter the hospital or seek care at a hospital outpatient facility on a daily basis. These caregivers are some of the best, caring for some of the sickness and most vulnerable

individuals from our surrounding towns, and they want to see Waterbury Hospital continuing to thrive throughout the next 125 years.

I am also convinced that Prospect Medical Holdings believes in the promise that Waterbury Hospital holds as the gold standard, putting patients first, and that, after all, is what health care is all about, the patients.

The proposed transaction will allow this fine institution to continue its great work for the community it serves. I urge state regulators to approve this conversion. Thank you for your time.

MR. CONTADINI: Thank you, Loraine. Before we continue, I'd like to introduce Senator Joan Hartley.

SENATOR HARTLEY: Good evening to you all. I saw Darlene yesterday and told you I'd be stopping by. I see a lot of familiar faces.

So, first of all, I want to welcome you to Connecticut, because I know you've been in other places here in the state, but also to Waterbury. This is my district. It's the heart of my district. I represent Waterbury, Middlebury, Naugatuck, and so this is going to be a long conversation, and it's a very important one.

We were just over at the community college yesterday talking about building the skilled pipeline, developing a med tech program, providing the skilled employees and workforce that is necessary to have an excellent program. I have read about you. I'm going to continue to learn a lot more about you. My apologies, I have not heard your pitch, but I know there is going to be time for that, and so we'll get to know each other very well.

But let me just say that this is a community that is a very engaged community. You have looked at our demographics. You are understanding who we are. But it is so important that we have world class health care here.

Now, it wasn't that many years ago that we were all working very hard to try to get cardiac care here, because what was going on was -- what was it, the ship and drip, the drip and ship onto Route 8, Route 84, totally unacceptable, and so with a great coming together of many of the people in this room, we were able to make our case through the regulatory process and to achieve that expertise and care. I am very concerned that we continue to grow those kinds of specialties here.

I'd also like to mention the fact that

some years ago, and I don't want to mention how long ago, we came together -- and long before Darlene, she's kind of a baby here -- to build a child care center here, the first one in the city of Waterbury. It was with state resources, and it has grown, and it basically set the threshold for everything that came after that, and to this day it is still a very excellent program. I am very concerned that we continue to operate that and support it in the same way that it always has, that this institution has.

And so with that, I understand the challenges that the health care industry faces. I myself, along with Craig Leroy here, have had many frustrating moments, and Darlene has been with us in the trenches on all of that, and that's, you know, probably not going to go away really quick, but nonetheless, you have people in this room and in this community who have incredible skill and resources and knowledge and most of all the will to make this the very best world class system.

So I read that you are -- you run things from distant places, and that concerns me. I like home town bankers. I like, you know, home town resources. We all know how comfortable you feel with that, but I understand the universe of what it

is, and so going forward, I want to know that we have the ability to be recognized and have resources as if they were home town.

So as I said, it's a long process. I'm here on behalf of the entire state delegation, and we will be rolling up our sleeves working with you hand and glove as we go through this. So once again, our welcome to you and look forward to many conversations.

MR. CONTADINI: Thank you, Senator Hartley. Tom, would you like to say a few words in regards to that?

MR. REARDON: Senator, thank you so much for your comments. I appreciate it very much. And by the way, thank you all for coming. Mitchell is from Los Angeles. I'm from Boston. And we have a philosophy, and I just wanted to -- Senator, you're misinformed on one point. We believe all health care is local. We cannot run things from Los Angeles. And so we are going to support the local management team, and we're going to have a local advisory board, and we are going to provide support for it, because it has to be local. And as I said, you folks are -- you know this community better than Mitchell or I will ever know this

community. So we need your input and your help on this. But thank you very much for your welcoming, and we're thrilled to be here. Thank you.

MR. CONTADINI: Thank you, Tom. Next I'd like to have Brian Emerich of Access Rehab.

MR. EMERICH: My name is Brian Emerich, and I'm the president for Access Rehab Centers, which a local rehabilitation company that has a partnership between Waterbury Hospital and Easter Seals of Greater Waterbury, and I'm also an occupational therapist by background.

I would first like to thank you all for the opportunity to share some thoughts regarding the proposed acquisition of Waterbury Hospital by Prospect Medical Holdings. I would respectfully ask that when considering this transaction, that we all need to take into account, into consideration that changes in the health care delivery system are coming in a pace that several years ago none of us would have dreamt would be possible. These changes are redefining the way health care facilities are reimbursed, how they treat patients and who they treat. The very foundations of the way that business is conducted is being changed. Even the definition of success is changed.

Health care is moving from quantity to quality. I for one applaud this move, and if it is done well, I truly believe that it is a win for the patient, it's a win for a quality health care system, a win for those paying for health care, and a win for the clinicians who will be able to focus on prevention and healing.

In many cases the best strategy for success is finding someone who can guide you and mentor you through the change process. Waterbury Hospital has chosen well with Prospect. They have the record for success in competing in this new market. They have a cutting edge business model that is both competitive and brings a fresh new way of embracing quality and empowering providers to focus on health management.

Everyone knows that hospitals are struggling under reduced reimbursements as well as significantly larger numbers of people who require services. As with much of Connecticut, our health care institutions are sloping down a very dangerous trend, reduced funding and increased demand. It is obvious that we are headed in the wrong direction. I ask you to remember that the first rule when you find yourself in a hole is you have to stop digging.

We need a new way to manage health care and health care costs.

Prospect brings new ideas, a proven track record and the capital that it will take to implement the necessary changes.

I have worked with Waterbury Hospital for over 15 years, and I can honestly say that the care of Waterbury Hospital today is the best that I've ever seen it in all those years. It is of a higher quality, and it is provided with a significantly higher degree of efficiency as well. Even with all of those positive changes, I can say that the expectations that are on hospitals today make it extremely hard to provide care and to keep the doors open. How many of the business owners in this community could stay open if there were an ever-increasing number of people walking through their doors who were required to pay below what that business' costs were for the goods that were being sold?

All across Connecticut we've been hearing about layoffs at various hospitals. Health care is not something we can afford to do like we have been doing in the past, but at the same time, we cannot afford as a society to allow our health

care systems to die on the vine. We have to change the way that we do business. We have to think differently. We have to reward quality providers who provide top quality care at a lower cost than others.

Prospect is willing to accept risk and health care delivery because they know how to prevent hospitalizations and keep people healthy. Isn't that what health care providers in general should be doing?

So why Prospect? I believe that Prospect is a great match for Waterbury Hospital and the entire Greater Waterbury Health Care Network because they see the business opportunity where others have yet to look. They are a clear leader and innovator and they bring a new commitment to partnering with the providers in the community and with the government as well as with payers. It is a model that has proven viable and has flourished elsewhere. It changes the equation. It's a way to mine the inefficiencies of our current health care system, and it reinvents the basic fundamental structure of health care delivery in such a way that going forward everyone should be able to focus and be rewarded for doing so on preventing illness and

reducing costs.

I respectfully ask that we all support the acquisition of Waterbury Hospital by Prospect Medical and, further, that we all support the concept of health management as a means to reinvest health care in our country. Thank you.

MR. CONTADINI: Thank you, Brian. Next I have Lynn Ward, Waterbury Regional Chamber of Commerce, but...

MR. KRECHEVSKY: Obviously, I'm not Lynn Ward. I am David Krechevsky. I am the Director of Public Policy and Economic Development for the Waterbury Regional Chamber for which Lynn is president and CEO. Unfortunately, she was supposed to be here tonight, but she's been delayed by another event, so I'm going to give her testimony on her behalf.

The Chamber serves 13 towns in greater Waterbury and represents the collective interests of more than 1,000 businesses in matters of public policy and economic development, and I'm here to express the Chamber's strong support for this transaction between Waterbury Hospital, its parent Greater Waterbury Health Network and Prospect Medical Holdings.

A strong, viable hospital and network of health care and medical services is critically important for Greater Waterbury and the businesses in our region. These are the resources that employers, employees and their families rely on for the full range of care from primary care to emergency services to state-of-the-art surgical care. The Chamber's public policy programming continually advocates for measures that improve the local quality of life, and we're aware that a strong health care system plays a crucial role in helping companies decide where to do business.

Hospitals today operate on a continually changing, highly competitive environment, and the proposed transaction would provide the hospital and the network with the resources needed to ensure they continue to deliver a high level of care.

As this transaction moves forward, it's important to remember that Waterbury Hospital and its affiliates provide more to this region than just health care services. The hospital is one of the city's largest employers and brings both direct and indirect economic benefits to our region. In fact, a recent economic impact study conducted by the

Connecticut Hospital Association found that Waterbury Hospital contributed more than $463 million to the region's economy in 2013 alone.

In addition, the Chamber's municipal agenda supports initiatives that expand the commercial segment of Waterbury's grand list. Growth in the tax base has a major impact on making the city more attractive to companies looking to expand or relocate, as well as serving to reduce the tax burden on existing businesses and residential tax payers. Because this proposal will provide a significant increase in local tax revenue, it both directly fosters economic development and improves the city's ability to attract future economic development.

Prospect Medical Holdings, meanwhile, will bring new resources, expertise and innovation that will help to meet the mutual goals of the business community and of local health care providers by improving the health of our communities while keeping costs in check. The issue of ensuring continued access to high quality care while controlling and reducing health care costs is a key priority for businesses as well as the health care industry.

Prospect has a proven model of health care delivery and payment system that has demonstrated improved health care outcomes while reducing the cost of care.

One of the more exciting aspects of Prospect's business model, known as "coordinated regional care," is that it brings together all parts of the health care system and community resources to effectively coordinate and manage care for the region's population. It will bring a true system of care to and partnership with many of the stakeholders in Greater Waterbury.

We look forward to the potential opportunities that Prospect offers to our region and our business community. The Waterbury Regional Chamber supports the acquisition of Waterbury Hospital and the Greater Waterbury Health Network recognizing the many benefits it brings for strengthening health care in our communities and contributing to the economic development of our region both now and for the long-term. Thanks for the opportunity to speak tonight.

MR. CONTADINI: Thank you. I see the real Lynn Ward has walked in.

MS. WARD: Great job, David.

MR. CONTADINI: Next I would like to call Dr. Scott Peterson of OptiCare.

MR. PETERSON: Good morning, everyone. My name is Scott Peterson. I'm an ophthalmologist, and I particularly appreciate the opportunity that we have in this community for the hearing that Darlene and the people from Prospect and Mr. Contadini have set up.

I was working in our garden today for a long time because everything is very dry, and I had -- I knew I was going to make some remarks tonight, and I couldn't help but remember that not too many years ago we had a garden party there for the cardiology department at Waterbury Hospital. And the reason that we had that is that I had been on the drip and ship program that Joan spoke about, and I'm here today, that was 15 years ago, but I am still so grateful for being able to water in my garden even when it's hot. And I can tell you -- and I'm sorry to go on, but I have to tell you this -- it was not a fun ride between Waterbury Hospital and Bridgeport. You couldn't help but think "what if." And so having all of these things here will be wonderful.

Just so you know who I am, I live in

Middlebury. I did my internship in Waterbury Hospital in 1971. I've been on the staff of the hospital ever since. I'm one of the founders of OptiCare which is Connecticut's largest eye care provider. I've been a chairman of the Department of Ophthalmology at the hospital. We don't have ophthalmology services now, but maybe they will come back. And I have many, many patients, multi-generational patients. So the future of the hospital is extremely important to me personally for my own health care, and it's also terribly important for all of the people that I take care of.

I love Waterbury Hospital, and I hope very much that whatever transpires has all the virtues that we all want them to do.

I have also been deeply involved over the last several decades in local philanthropy. I was the president of the Connecticut Community Foundation, and I've been active on many boards over the years, and it's this area that I want to address in my remarks tonight, which are, in fact, questions, not questions that can be necessarily answered tonight, but questions that have been alluded to already, but that I think bear continuing scrutiny, and I know that they will receive that.

I realize that the foundation will be separate, but I am concerned that such may not be -- that that alone -- that the paperwork may not alone be enough to fully protect the millions of dollars that donors have provided to the hospital over many, many years. I would like to know how this piece of the financial picture is calculated. I would like to know what outside oversight there will be in addition to the AG and in addition to the local committee. It needs to be completely independent of the hospital and completely independent of politics. It really needs to be a representative of the community.

I remember quite well the very -- at least for me -- the very unhappy results of the tobacco settlement money in Connecticut which really became one giant political honey pot. And I also remember what happened to the Anthem Blue Cross money. That also became a kind of political football that in some respects I still think is somewhat suspect. And out of respect to the hundreds and thousand of donors that have contributed in good faith to a community hospital, a nonprofit entity, I hope that that will be safeguarded in perpetuity.

So will the foundation assets be tapped, for example, for fees for indigent patients such that now the for-profit receives money for their care, whereas before, the hospital, whether for better or worse, provided those services at no cost?

There are many such questions and there are many people, experts in this area, and I certainly don't profess to be such an expert, but I do hope that their opinions will be sought and consulted and that we can all be proud in the end of not only the world class health, which I have no doubt will occur, but of the world class ethical and moral underpinnings of the new venture. So I hope that these questions will be given very thorough study and discussion by the commission and by all parties concerned. Thank you very much.

MR. CONTADINI: Thank you, Dr. Peterson. I'd like to have Ann Zucker address some of those concerns. The -- as we proceeded with this transaction, one of the things that was very important to us was the foundation and how do we preserve that foundation on an ongoing basis. And, again, the important thing is, is when we started on this road five years ago, we went and we told

everybody this is for real, we need to do this, because while we have some assets left, we need to protect them as we move forward. And five years have gone by, and those assets become less and less over time. However, we've done a lot of work in that area, and Ann is really the expert in that area, and she can, I think, put to rest many of those concerns you have. And if you feel that the answers are not clear, I would ask you to readdress them because I think this is important because the foundation is the legacy that will be left from the past. So Ann?

MS. ZUCKER: Hello, Dr. Peterson. How are you? Your concerns were exactly the same concerns that our board had, and Carl just expressed many of them.

The attorney general's office is tasked with making sure that each of those funds is put to an appropriate use. We are required, and the attorney general's office made sure we did this last time, to deliver a copy of each of the instruments that gave funds to the hospital. So some of those instruments go back to the late 1800's, early 1900's, and so we had to track each one of them down, unearthing things from probate courts,

archives in many different towns. There is a fellow at the attorney general's office who pours over the language of each of those specific documents and, if you look at the last decision in our previous hearing, made some very specific recommendations about what could be done with those funds and what could not be done with those funds. So a lot of attention is being spent on each of those individual pots of money.

One of the other things you raised was who would be overseeing these funds and whether there would be any sort of conflict of interest with respect to -- and I guess perhaps you're thinking about perhaps people sitting on both boards of the hospital or the advisory board of the hospital and our community foundation. And I believe that the statute prohibits that from happening. So those -- there will not be any commonality between those boards in order to keep it separate from any conflicts of interest. So you should get some assurances there.

And then I think I'm going to answer the last question you asked, and that is, could the funds from our charitable foundation be used to provide indigent care that our successor for-profit

hospital should be providing, and the answer to that is no. Prospect has agreed to step into our shoes on the charity care policies that we have now. It is not permissible for a tax-exempt organization to provide funds that will benefit even indirectly a for-profit. And I'm sure they've been through this up in Rhode Island just a year or two ago. So I don't think there's any expectation on Prospect's part, nor our board's part, that those funds would be used to benefit the successor hospital.

We very much appreciate your concerns and your voicing them and taking the time to think about those things, because they're hard things, and our board has paid a lot of attention to them. So thank you, and thank you for being a hospital supporter for a long time.

DR. PETERSON: You're welcome, and I know the good people have thought of these things.

MS. ZUCKER: Thank you.

MR. CONTADINI: Thank you. Okay. At this point in time I'd like to offer one more time if anybody here in the audience would like to ask any questions. The decision-makers are all here in this room. Now is your time. And I think that if you'd like to, I would -- you know, we're at the end

of the list, so I would like to offer that one more time. Again, our objective here is to get participation from the public. And your questions -- you know, I know this is a hard thing for some people to do because they think their question isn't important, but it is probably important. We don't know all the questions that you have on your mind. So I'd like to give you a couple minutes to think about it before I conclude this meeting. So I give you two minutes, and if you'd like to -- if you'd -- somebody would like to think about asking some questions, I would encourage you to do so. So the clock is ticking.

MR. RHODES: Robert Rhodes, retired United Methodist minister, and also I was with the hospital 12 years in the pastoral care department. I'm just so happy that the good doctor, my ophthalmologist, I can still see, and I am so happy about the foundation. The predecessor with the previous group, I talked with them, Mr. O'Meara, on a couple occasions about the foundation because I haven't heard much about it.

Secondly, as you know, some of my brothers and sisters in the clergy attempted to get into the hospital to present their cause. I did not

know about that.

I look at the foundation -- and I realize this isn't a question -- as a very creative possibility to link the hospital with the community and their concerns. And we talked recently about people ruling us from afar, and you answered that very well, but I just want to thank him for that, and I believe the foundation can be a very creative instrument and address a lot of the needs of the community. Thank you.

MR. CONTADINI: Thank you.

MS. ORGANIC: Hello. My name is Carol Organic, and I'm a member of the Waterbury community. I've lived here for approximately 30 years. I'm originally from Massachusetts, and I had the honor and privilege of having surgery at Waterbury Hospital most recently about six months ago. I had both my hips replaced by Dr. Keggi, and I was very happy with the outcome and my experience.

I have one question for all of you, and that is -- I don't know if you can answer it today, but I think there have been a lot of joint ventures with Saint Mary's Hospital in the past, and I didn't know how those were going to be separated. Your cardiology, your surgery center, your cancer center,

etc., how are those going to be broken up into the community. I know you probably can't answer it today, but perhaps in the future.

MR. CONTADINI: I think we can give you an answer. Ann?

MS. ZUCKER: Those are very important services in our community, so thank you for bringing that up. Perhaps I should have covered that in my presentation.

So you're exactly correct, that we're working through the legalities on those issues, but I understand that Prospect, as well as our board, is committed to having those services continue to be in our community. So we're working on the fine points, but we're all committed to continue to have cardiology and oncology services in the community.

MR. CONTADINI: Okay. Is there anyone else? Two minutes is gone. Okay. With that, I'd like to thank everybody for coming here this evening, for your participation and your attendance. It's very important. And this concludes the public hearing, first public hearing, at Waterbury Hospital. Again, thank you very much.

(Hearing concluded: 06:37 p.m.)

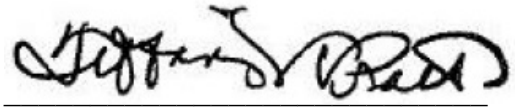
C E R T I F I C A T I O N

STATE OF CONNECTICUT:
COUNTY OF HARTFORD:

I, TIFFANY V. PRATT, a Notary Public duly commissioned and qualified in and for the State of Connecticut, do hereby certify that the foregoing 65 pages are a complete and accurate computer-aided transcription of my Stenotype notes taken in the matter of the Public Hearing re. Greater Waterbury Health Network/Prospect Medical Holdings Transaction taken on Wednesday, August 5, 2015.

I further certify that I am a Notary Public duly commissioned and qualified to administer oaths in the State of Connecticut.

In witness whereof I have hereunto set my hand this 11th day of August, 2015.



Tiffany V. Pratt
Notary Public

My Commission expires:
July 31, 2020

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EXHIBIT Q16-1

SUPPLEMENTAL CON APPLICATION

Supplemental CON Application Form

Acquisition of Equipment

Conn. Gen. Stat. § 19a-638(a)(10),(11)

Applicant: Greater Waterbury Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Name: Acquisition of Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.

Affidavit

Applicant: Prospect Medical Holdings, Inc.

Project Title: Acquisition of Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.

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

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

Signature 10/16/2015 Date

Subscribed and sworn to before me on _____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____ ofb. see attached.

JURAT

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

State of California
County of Los Angeles

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

by * * * SANG BUM LEE * * * * * * * * *

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

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

Signature E. Lucas (Seal)

AFFIDAVIT

Applicant: Greater Waterbury Health Network, Inc.

Project Title: Acquisition of The Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.

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

Signature

10/19/15
Date

Subscribed and sworn to before me on October 19, 2015

Jan Balzarini

Notary Public / Commissioner of the Superior Court

My commission expires: 7-31-16

{W2597163}

1. Project Description: Acquisition of Equipment

Waterbury Hospital in Waterbury, Connecticut provides a broad range of imaging services on its hospital campus including computed tomography ("CT") scanners, digital mammography, ultrasound, diagnostic x-ray, interventional radiology, MRI (through Greater Waterbury Imaging Center) and nuclear medicine.

Greater Waterbury Health Network, Inc. ("GWHN"), the parent company of Waterbury Hospital, is contemplating entering into an Asset Purchase Agreement (the "Asset Purchase") with Prospect Medical Holdings, Inc. ("Prospect" or "PMH") with the intent to sell substantially all of GWHN's assets to PMH or one or more affiliates of PMH. As part of the proposed Asset Purchase, a PMH subsidiary that will continue the operations of Waterbury Hospital will acquire the CT scanners currently operated by Waterbury Hospital on the hospital campus.

Following the Asset Purchase, there will be no change in operations or services offered by Waterbury Hospital as a result of GWHN transferring its interests to PMH. Waterbury Hospital will continue to offer the same level of care to the same communities that are served by Waterbury Hospital. The Applicants do not anticipate any changes to the patient population or payor mix at Waterbury Hospital or any adverse impact on the communities' access to CT services.

a. Provide the manufacturer, model and number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Equipment	Manufacturer	Model	Slices/Strength	Use
CT	GE	HiSpeed Cti	Single Slice	Replaced June 2015
CT	Toshiba	Aquillon	64 Slice	
CT	Prime CT	Prime CT	80 Slice	Effective June 2015

b. List each of the Applicant's sites and the imaging modalities currently offered by location.

Waterbury Hospital is located at 64 Robbins Street, Waterbury, Connecticut. Imaging services provided at this location include:

- CT scans;
- Digital mammography;
- Ultrasound;
- Diagnostic x-ray;

- Interventional radiology;
- MRI (through Greater Waterbury Imaging Center); and
- Nuclear medicine.

2. Clear Public Need

a. Complete Table A for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

TABLE A
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Service*	Days/Hours of Operation **	Utilization***
Waterbury Hospital 64 Robbins Street Waterbury, Connecticut	CT (Single Slice until June 2015; 80 slice effective June 2015)	7 days a week/24 hours a day	19,213 combined[1] for FY 2015
Waterbury Hospital 64 Robbins Street Waterbury, Connecticut	CT (64 Slice)	7 days a week/24 hours a day	

*Include equipment strength (e.g. slices, tesla strength), whether the unit is open or closed (for MRI)
**Days of the week unit is operational, and start and end time for each day
***Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

b. Provide the rationale for locating the proposed equipment at the proposed site;

The Applicants are proposing to transfer ownership of the existing CT scanners at the 64 Robbins Street location to a subsidiary of PMH that will continue the operations of Waterbury Hospital and its on-campus CT scanner services as part of part of the proposed Asset Purchase. Following the Asset Purchase, no change in the location of CT scanners is anticipated as a result of GWHN transferring its interests to PMH.

3. Actual and Projected Volume

a. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each of the Applicant's existing and proposed pieces of equipment (of the type proposed, at the proposed location only). In Table B, report the units of service by piece of equipment, and in Table C, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

[1] Please note that GWHN does not keep separate utilization records for each of its scanners.

TABLE B

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT[2]

Total CT Machines

Equipment***	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Inpatient	6,307	5,911	6,581	6,484	6,484	6,484	6,484
Outpatient	2,728	4,301	4,521	4,808	4,808	4,808	4,808
ED	6,327	7,111	7,802	7,921	7,921	7,921	7,921
Total	**15,407**	**17,323**	**18,904**	**19,213**	**19,213**	**19,213**	**19,213**

*For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
**If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
***Identify each scanner separately and add lines as necessary. Also break out inpatient/outpatient/ED volumes if applicable.
****Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

TABLE C

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY TYPE OF SCAN/EXAM

****PLEASE SEE ATTACHED EXHIBIT TABLE C FOR INFORMATION REQUESTED.**

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Volume projections by scanner and scan type assumes that utilization will remain constant at FY 2015 levels through FY 2018.

c. Explain any increases and/or decreases in the volume reported in the tables above.

Increases and decreases are based on normal volume fluctuation.

d. Provide a breakdown, by town, of the volumes provided in Table C for the most recently completed FY.

[2] Please note that GWHN does not keep separate utilization records by equipment unit.

TABLE D

UTILIZATION BY TOWN

****PLEASE SEE ATTACHED EXHIBIT TABLE D FOR INFORMATION REQUESTED. PLEASE NOTE THAT GWHN DOES NOT KEEP SEPARATE UTILIZATION RECORDS BY EQUIPMENT UNIT.**

Equipment*	Town	Utilization FY 2015
CT		

*Identify each scanner separately and add lines as necessary. Also, break out inpatient/outpatient/ED volumes if applicable and include equipment strength (e.g., slices, tesla strength), whether the unit is open or closed (for MRI).
**Fill in year

EXHIBIT TABLE

Waterbury Hospital

CPT CODE & DESCRIPTION	FY 2012	FY 2013	FY 2014	FY 2015
70450 - CT HEAD/BRAIN W/O DYE	5437	5736	6091	5736
70460 - CT HEAD/BRAIN W/DYE	59	31	33	32
70470 - CT HEAD/BRAIN W/O & W/DYE	59	42	39	33
70480 - CT ORBIT/EAR/FOSSA W/O DYE	37	54	74	47
70481 - CT ORBIT/EAR/FOSSA W/DYE	38	25	21	29
70482 - CT ORBIT/EAR/FOSSA W/O&W/DYE	9	7	5	8
70486 - CT MAXILLOFACIAL W/O DYE	400	559	625	609
70487 - CT MAXILLOFACIAL W/DYE	19	15	19	23
70488 - CT MAXILLOFACIAL W/O & W/DYE		1		1
70490 - CT SOFT TISSUE NECK W/O DYE	30	49	49	60
70491 - CT SOFT TISSUE NECK W/DYE	139	170	150	169
70492 - CT SFT TSUE NCK W/O & W/DYE	1	3	2	1
70496 - CT ANGIOGRAPHY HEAD	38	66	153	140
70498 - CT ANGIOGRAPHY NECK	56	81	159	145
71250 - CT THORAX W/O DYE	793	997	1086	1196
71260 - CT THORAX W/DYE	1639	1815	1987	2085
71270 - CT THORAX W/O & W/DYE		8		44
71275 - CT ANGIOGRAPHY CHEST	8	12	30	21
72125 - CT NECK SPINE W/O DYE	756	1059	1264	1304
72126 - CT NECK SPINE W/DYE	3	3	3	4
72127 - CT NECK SPINE W/O & W/DYE	1		1	1
72128 - CT CHEST SPINE W/O DYE	34	36	42	38
72129 - CT CHEST SPINE W/DYE	5	2	2	2
72131 - CT LUMBAR SPINE W/O DYE	127	172	206	239
72132 - CT LUMBAR SPINE W/DYE	11	8	5	8
72133 - CT LUMBAR SPINE W/O & W/DYE	1			
72191 - CT ANGIOGRAPH PELV W/O&W/DYE	10	5	11	3
72192 - CT PELVIS W/O DYE	61	78	80	97
72193 - CT PELVIS W/DYE	34	29	35	36
72194 - CT PELVIS W/O & W/DYE	0	3	4	8
73200 - CT UPPER EXTREMITY W/O DYE	49	56	50	70
73201 - CT UPPER EXTREMITY W/DYE	3	1	9	13
73206 - CT ANGIO UPR EXTRM W/O&W/DYE	3	2	3	1
73700 - CT LOWER EXTREMITY W/O DYE	131	125	170	174
73701 - CT LOWER EXTREMITY W/DYE	13	15	18	22
73706 - CT ANGIO LWR EXTR W/O&W/DYE	4	3	4	3
74150 - CT ABDOMEN W/O DYE	71	79	83	60
74160 - CT ABDOMEN W/DYE	188	194	165	186
74170 - CT ABDOMEN W/O & W/DYE	10	15	9	16
74174 - CT ANGIO ABD&PELV W/O&W/DYE	6	23	25	25
74175 - CT ANGIO ABDOM W/O & W/DYE	7	7	11	7
74176 - CT ABD & PELVIS W/O CONTRAST	3001	2791	3433	3407
74177 - CT ABD & PELV W/CONTRAST	1785	2518	2402	2731
74178 - CT ABD & PELV 1/> REGNS	142	204	157	158
74261 - CT COLONOGRAPHY DX	2	1	1	4
74263 - CT COLONOGRAPHY SCREENING	1		3	2
75571 - CT HRT W/O DYE W/CA TEST	1			
75574 - CT ANGIO HRT W/3D IMAGE	5			
75635 - CT ANGIO ABDOMINAL ARTERIES	23	38	35	51
77012 - CT SCAN FOR NEEDLE BIOPSY	133	143	150	147
77013 - CT GUIDE FOR TISSUE ABLATION	2			0
77014 - CT SCAN FOR THERAPY GUIDE	22	42	0	17
Grand Total	**15407**	**17323**	**18904**	**19213**

EXHIBIT TABLE

DATA BASE	2015
PT-ST	CT
TOWN	**# OF CT SCANS**
Ansonia	20
Avon	2
BANTAM	8
BEACON FALLS	158
BETHANY	37
Bethel	13
BETHELHEM	3
BETHLEHEM	166
Bridgeport	37
BRIDGEWATER	6
Bristol	85
Brookfield Center	11
BURLINGTON	6
Canton	1
CHESHIRE	173
Cos Cob	1
Danbury	38
Deep River	1
Derby	13
Durham	1
East Haddam	1
East Hartford	1
EAST HAVEN	10
Easton	8
ENFIELD	2
Fairfield	2
FARMINGTON	1
Forestville	1
Glastonbury	11
Goshen	23
Greenwich	5
Guilford	1
Haddam Neck	1
HAMDEN	3
Hartford	18
HARWINGTON	1
HARWINTON	18
HUNTINGTON	1
Kenington	1
Killingworth	1
LAKESIDE	5
Litchfield	42
Manchester	2
MANSFIELD	1

TOWN	# OF CT SCANS
Marion	3
Meriden	42
MIDDLEBURY	533
Middlefield	2
Middletown	5
Milford	12
MILLDALE	1
Monroe	13
Morris	54
NAUGATUCK	1,999
NEW BRITAIN	14
New Canaan	2
New Hartford	5
New Haven	35
New London	1
NEW MILFORD	17
Newington	4
Newtown	13
Norfolk	6
North Franklin	4
North Haven	1
NORTHFIELD	42
Norwalk	7
NORWICH	1
OAKVILLE	819
Orange	6
Oxford	145
Plainville	17
Plantsville	24
Plymouth	103
Prospect	419
Redding	2
Ridgefield	4
Rockfall	2
ROCKVILLE	1
Rocky Hill	8
ROXBURY	10
Sandy Hook	7
Seymour	67
Shelton	15
Sherman	1
SimSbury	1
SOUTH BRITAIN	1
South Norwalk	5
SOUTHBURY	930
SOUTHINGTON	76

TOWN	# OF CT SCANS
Stamford	4
Stratford	12
Talcott Village	6
Terryville	141
THOMASTON	558
Tolland	1
TORRINGTON	222
Trumbull	1
Unionville	3
VERNON	1
WALLINGFORD	3
WARREN	4
Washington	2
Waterbury	9,153
WATERTOWN	1,321
West Hartford	8
West Haven	16
West Redding	1
Wethersfield	1
Whitneyville	2
WINCHESTER CENTER	1
Windsor	2
Winsted	34
WOLCOTT	537
Woodbridge	9
WOODBURY	514
WOOODBURY	1
Yalesville	12
Grand Total	**18,989**
Outside of Connecticut	224
	19,213

EXHIBIT Q22-1

2013 WATERBURY HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT

GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP

Community Health Needs Assessment

Final Summary Report

September 2013

HOLLERAN

01076

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Greater Waterbury Health Improvement Partnership led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2012. The partnership consisted of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled the Greater Waterbury Health Improvement Partnership to take an in-depth look at its greater community. The findings from the assessment were utilized by the partnership to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The Greater Waterbury Health Improvement Partnership is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Statistical Data Profile of Waterbury, Connecticut and surrounding cities
- Household Telephone Survey with 1,100 community residents
- Focus Group Discussions with 24 health care providers and 33 community residents
- Key Informant Interviews with 205 community leaders and partners
- Prioritization Session
- Hospital Implementation Plans
- Community Health Improvement Plan (CHIP)

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the Greater Waterbury Health Improvement Partnership plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

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

Documentation

A final report of the CHNA was made public in September 2013 and can be found on the partner's websites. Hospital Implementation Plans, as well as a Community Health Improvement Plan (CHIP), were developed and adopted by each appropriate authority in September 2013.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Background

The Greater Waterbury Health Improvement Partnership is made up of a group of not-for-profit organizations serving the residents of Waterbury, Connecticut and surrounding communities. The Greater Waterbury Health Improvement Partnership defined their current service area as the City of Waterbury and the surrounding communities served by Saint Mary's Hospital and Waterbury Hospital. The area encompasses southwest Connecticut and is relatively large with a population of approximately 313,000 residents. The geographic area was defined by primary service area (PSA) and secondary service area (SSA). The PSA is the area that the partnership predominantly serves and the hospitals main catchment area. It comprises all of Waterbury and has a population of approximately 110,000 residents. The SSA includes portions of the surrounding communities served by the two hospitals and has a population of approximately 203,000 residents. The conclusions drawn from the various research components focus on the primary service area, the town of Waterbury, Connecticut.

CHNA Partners

- The City of Waterbury
- Connecticut Community Foundation
- Saint Mary's Hospital
- StayWell Health Center
- Waterbury Department of Public Health
- Waterbury Hospital
- The United Way

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

Quantitative Data:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates and other health statistics for Waterbury, Connecticut and surrounding cities was compiled.

- A Household Telephone Survey was conducted with 1,100 randomly-selected community residents. The survey was modeled after the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) which assesses health

status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

Qualitative Data:

- Six Focus Groups were held with 24 health care providers and 33 community residents in February 2013.

- Key Informant Interviews were conducted with 205 community leaders and partners between February and April 2013.

Research Partner

The Greater Waterbury Health Improvement Partnership contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data
- Conducted, analyzed, and interpreted data from the household telephone survey
- Conducted focus groups with community members
- Conducted key informant interviews with community leaders and partners
- Facilitated a Prioritization and Planning Session
- Prepared all reports

Community Representation

Community engagement and feedback were an integral part of the CHNA process. The Greater Waterbury Health Improvement Partnership sought community input through focus groups with health care providers and community members, key informant interviews with community leaders and partners, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

It should be noted that the availability and time lag of secondary data may present some research limitations. Additionally, language barriers, timeline, and other restrictions may have impacted the ability to survey all community stakeholders. The Greater Waterbury Health Improvement Partnership sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, the Greater Waterbury Health Improvement Partnership prioritized community health issues and developed an implementation plan to address prioritized community needs.

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to create a Secondary Data Profile. Secondary data is comprised of data obtained from existing resources and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health indicators, among other data points. The data was gathered and integrated into a graphical report to portray the current health and socio-economic status of residents in the Greater Waterbury Health Improvement Partnership service area.

Secondary data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Waterbury Department of Health, and the Connecticut Department of Public Health. Data sources are listed throughout the report and a full reference list is included in Appendix A. The data represents a point in time study using the most recent data possible. When available, state and national comparisons are provided as benchmarks.

The profile details data covering the following areas:

- Demographic/Socioeconomic Statistics
- Mortality Statistics
- Maternal & Child Health Statistics
- Sexually Transmitted Illness & Communicable Disease Statistics
- Mental Health Statistics
- Cancer Statistics
- Environmental Health Statistics
- Health Care Access Statistics
- Crime Statistics

Secondary Data Profile Key Findings

This section serves as a summary of the key takeaways from the secondary data profile. A full report of the findings is available through the Greater Waterbury Health Improvement Partnership.

Demographic Statistics

According to U.S. Census Bureau estimates (2009-2011), the total population in Waterbury, Connecticut is 110,075, a decline of 2.55% since 2000. The majority of residents identify as White (58.2%), indicating a less diverse population when compared to peer cities, but a more diverse population when compared to all of Connecticut. Approximately 19% of residents identify as Black/African American and 30.1% identify as Hispanic or Latino. The primary spoken language is English, but 31.6% of residents speak a language other than English at home. The median age in Waterbury is 35.2, which denotes a younger population when compared to Connecticut, but an older population when compared to most peer cities (U.S. Census Bureau, 2012).

Table 1. Overall Population (2009-2012)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
White	78.6%	58.2%	32.2%	46.7%	48.6%	59.6%
Black/African American	9.8%	19.4%	37.2%	34.4%	34.5%	14.8%
Asian	3.8%	1.7%	2.5%	4.9%	3.6%	8.05%
Two or more races	2.3%	5.6%	4.0%	2.9%	1.9%	1.7%
Hispanic or Latino (of any race)[b]	13.0%	30.1%	42.4%	26.3%	36.7%	24.4%

Source: U.S. Census Bureau, 2012

[a] Percentages may equal more than 100% as individuals may report more than one race

[b] Hispanic/Latino residents can be of any race, for example, White Hispanic

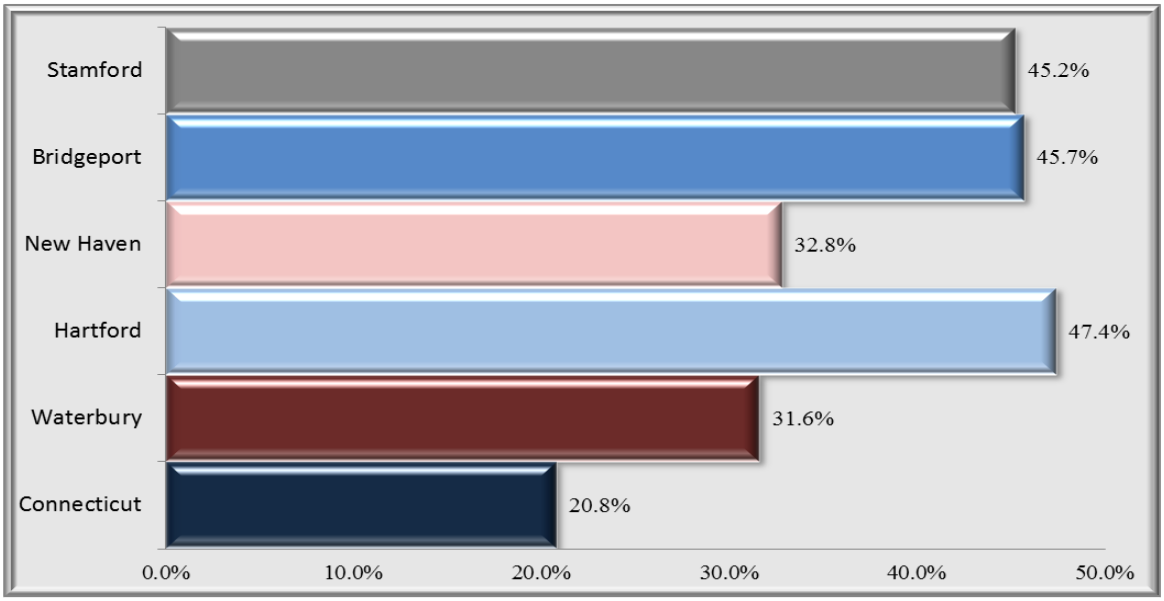


Figure 1. Percentage of population speaking a language other than English, 2009-2011
Source: U.S. Census Bureau, 2012

Waterbury is comprised primarily of family households (63.2%), which are defined as more than one person living together, either as relations or as a married couple. These households and nonfamily households are less likely to live in owner-occupied units (49.6%) compared to Connecticut (68.9%), but more likely to live in owner-occupied units compared to most peer cities. The median value for owner-occupied units is $164,000, which is lower than the median value across the state ($293,100) and all peer cities (U.S. Census Bureau, 2012).

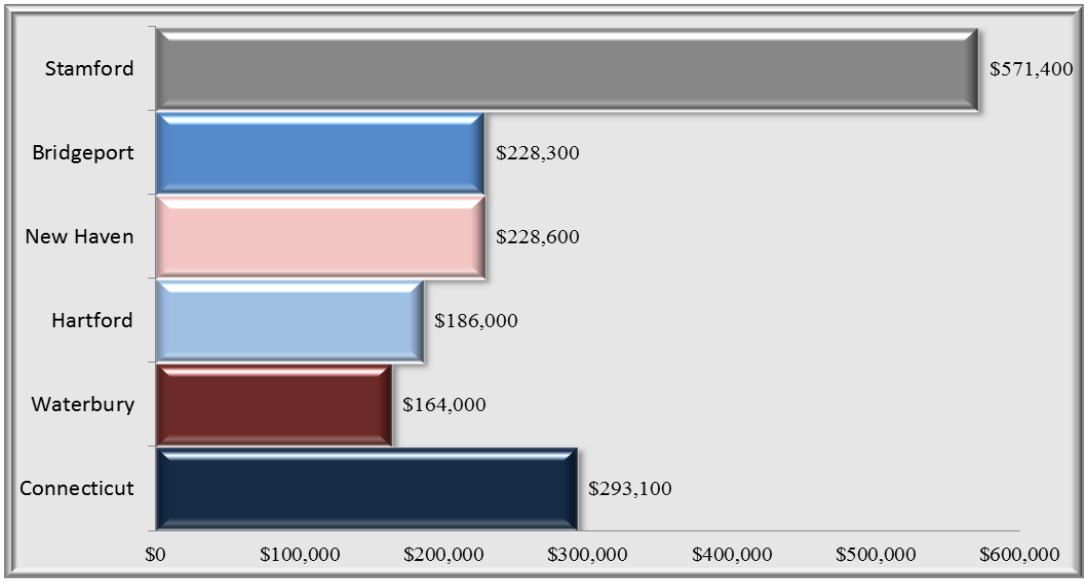


Figure 2. Median value for owner-occupied unit, 2009-2011
Source: U.S. Census Bureau, 2012

Approximately 40% of Waterbury residents aged 15 years and over have never been married. This is greater than the percentage across Connecticut (31.8%), but lower than the percentage across most peer cities. Among those residents who have been married, a higher percentage are divorced (11.6%) compared to Connecticut (10.2%) and all peer cities (U.S. Census Bureau, 2012).

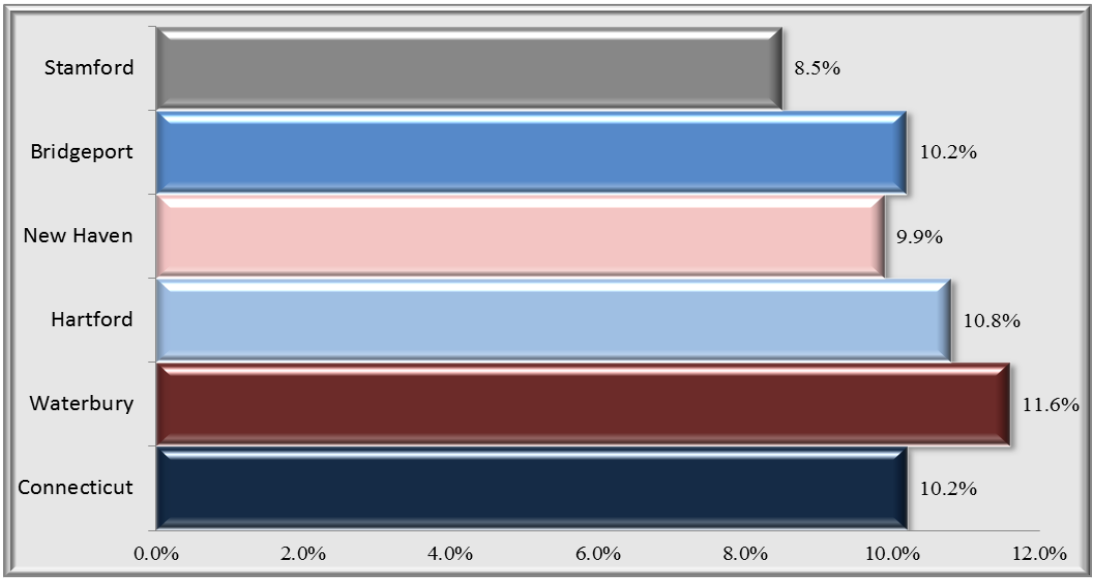


Figure 3. Divorce Rate, 2009-2011
Source: U.S. Census Bureau, 2012

The median income for households and families across Waterbury ($41,499 and $49,059 respectively) is lower than across all of Connecticut ($69,243; $86,395). However, it is higher when compared to most peer cities. The same trend is true of the median income for workers. The percentage of families and individuals living in poverty in the past 12 months is higher in Waterbury than in all of Connecticut (U.S. Census Bureau, 2012). More residents in Waterbury are also enrolled in social assistance programs like Temporary Family Assistance and Medicaid when compared to Connecticut and most peer cities. Between the years 2011 and 2012, 28.2% of residents were enrolled in Temporary Family Assistance and 38.1% were enrolled in Medicaid. Medicaid enrollment has been on the rise across all of Connecticut and its cities since 2006 (Connecticut Department of Social Services, n.d.).

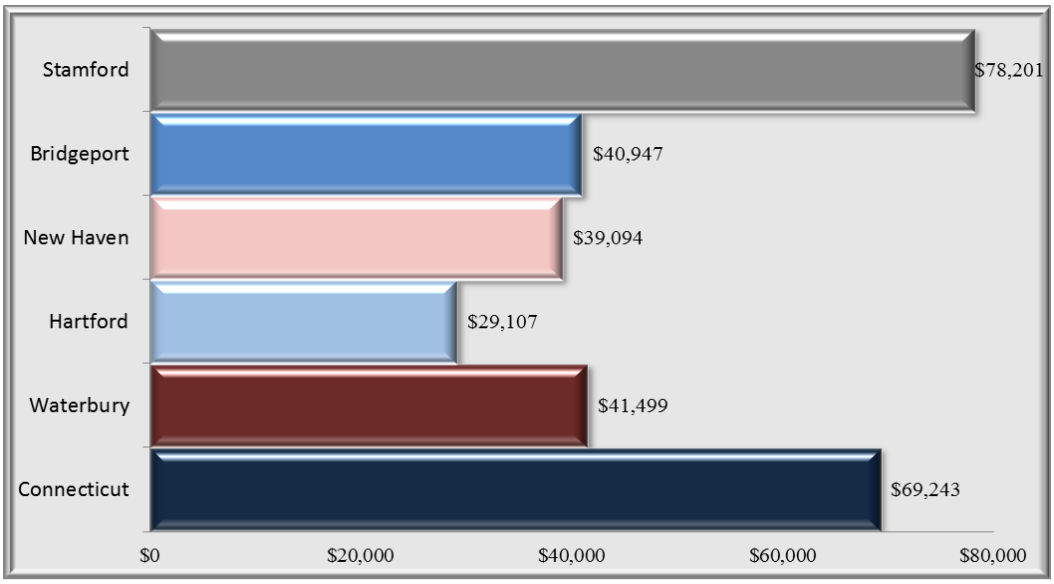


Figure 4. Median household income, 2009-2011
Source: U.S. Census Bureau, 2012

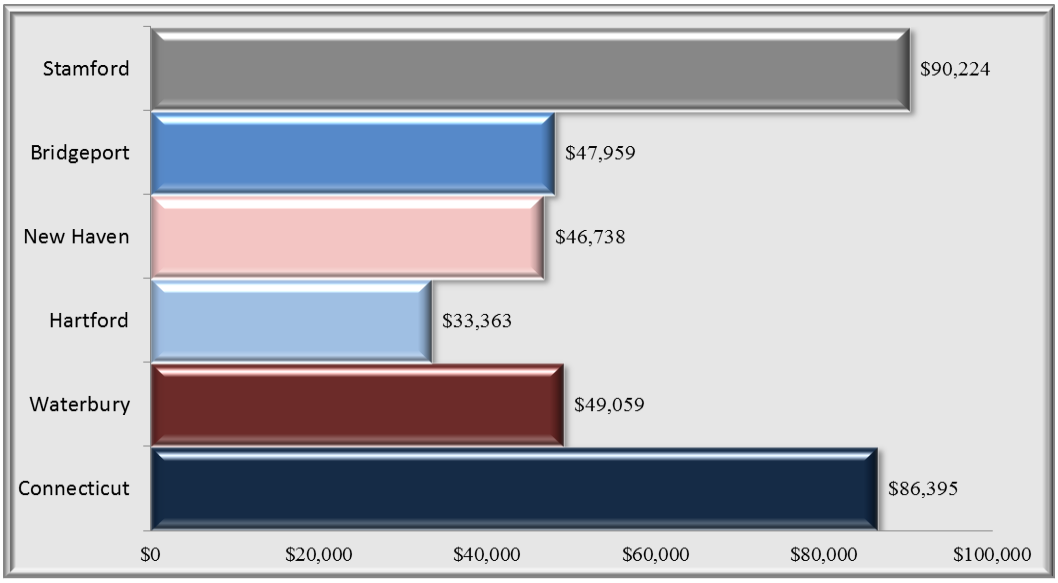


Figure 5. Median family income, 2009-2011
Source: U.S. Census Bureau, 2012

Table 2. Poverty Status of Families and People in the Past 12 Months (2010)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Families	6.7%	17.1%	29.9%	20.8%	18.0%	7.5%
With related children < 18 years	10.8%	26.3%	39.3%	30.0%	25.3%	11.6%
With related children < 5 years	12.5%	22.4%	46.1%	21.3%	20.6%	12.7%
Married couple families	2.3%	5.6%	9.3%	7.4%	7.3%	3.4%
With related children < 18 years	3.1%	7.7%	12.1%	11.2%	10.7%	4.5%
With related children < 5 years	3.4%	7.5%	11.3%	9.2%	6.0%	3.8%
Families with female householder, no husband present	22.9%	35.5%	44.5%	36.9%	34.1%	22.1%
With related children < 18 years	30.8%	44.3%	51.6%	44.9%	40.8%	30.4%
With related children < 18 years	40.1%	47.7%	60.8%	42.7%	41.1%	35.8%
All people	9.5%	20.6%	32.9%	26.3%	21.9%	11.0%

Source: U.S. Census Bureau, ACS estimates

According to the U.S. Census Bureau (2012), the unemployment rate in Waterbury is 12.7%. This rate is higher than the unemployment rate across Connecticut (8.5%). It is favorable or comparable to peer cities. Of the residents who are employed, the majority work in management, business, science, and arts and are private wage and salary workers. A notable percentage of residents are also employed in a service occupation.

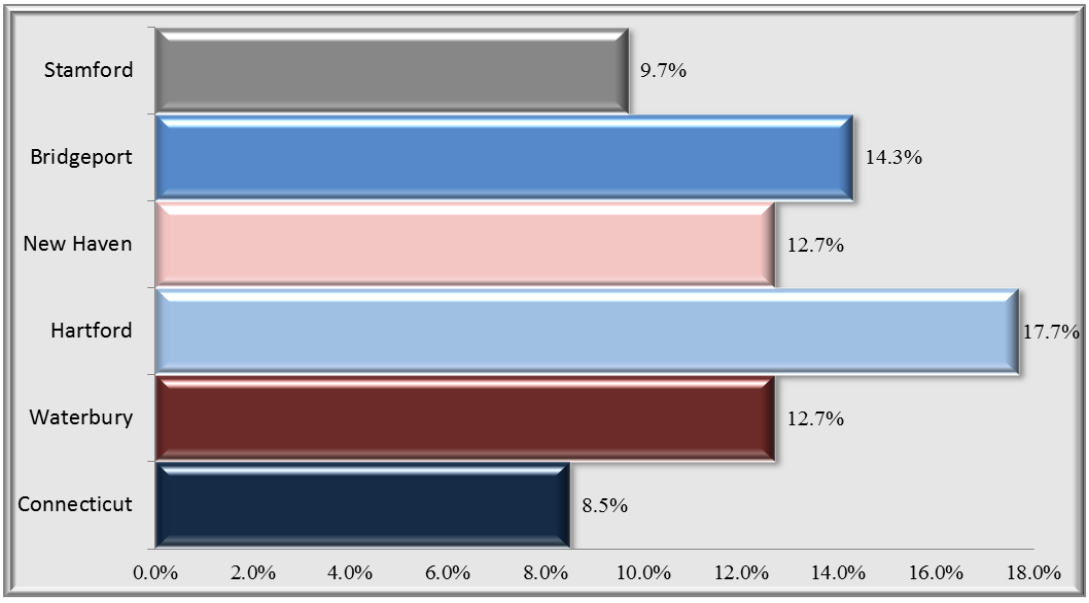


Figure 6. Unemployment rate for civilian labor force, 2009-2011
Source: U.S. Census Bureau, 2012

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. High school and higher education graduation rates are lower in Waterbury (78.7% and 17.2% respectively) than in Connecticut (88.6% and 35.7% respectively) and comparable to peer cities (U.S. Census Bureau, 2012).

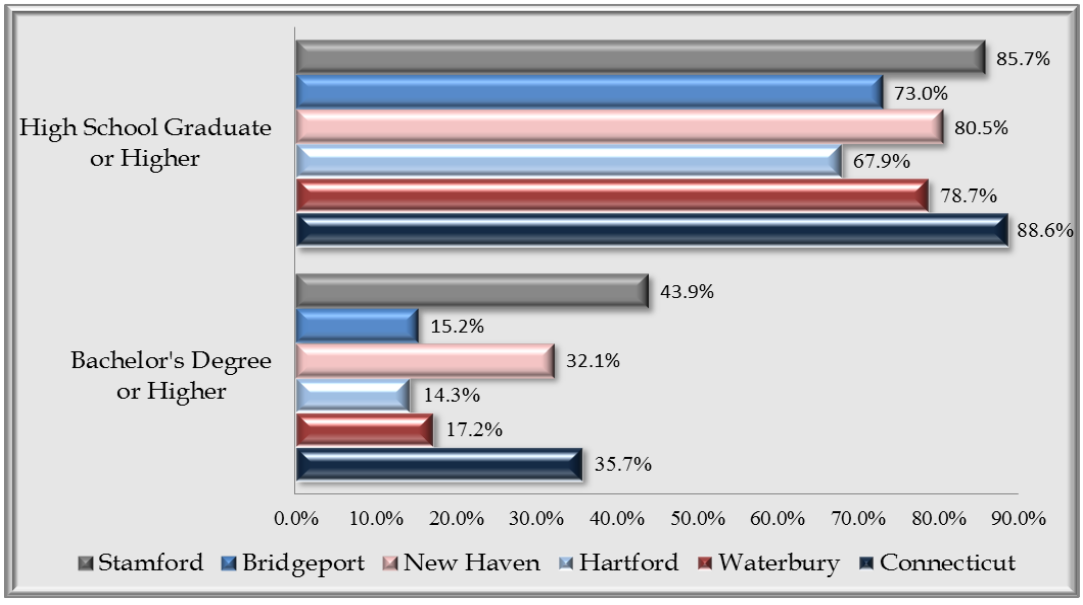


Figure 7. Educational attainment, 2009-2011
Source: U.S. Census Bureau, 2012

Health Status Indicators

Mortality Rates

The overall crude mortality rate for Waterbury, Connecticut is 9.2 per 1,000. This is higher than the mortality rate for Connecticut (8.1 per 1,000) and peer cities. A contributing factor to the higher overall mortality rate in Waterbury compared to peer cities may be its slightly older population. However, this does not apply when comparing to all of Connecticut as the state has a higher median age (Connecticut Department of Public Health, 2011).

The graphs below detail the age-adjust deaths rates per 100,000 for three of the leading causes of death in Waterbury. For all causes, Waterbury has a higher death rate than Connecticut. For chronic lower respiratory disease, Waterbury has a higher death rate (37.2) than Connecticut and all peer cities. Death rates due to heart disease and cancer in Waterbury are comparable to peer cities, but are still of concern as the top two leading causes of death (Connecticut Department of Public Health, 2011).

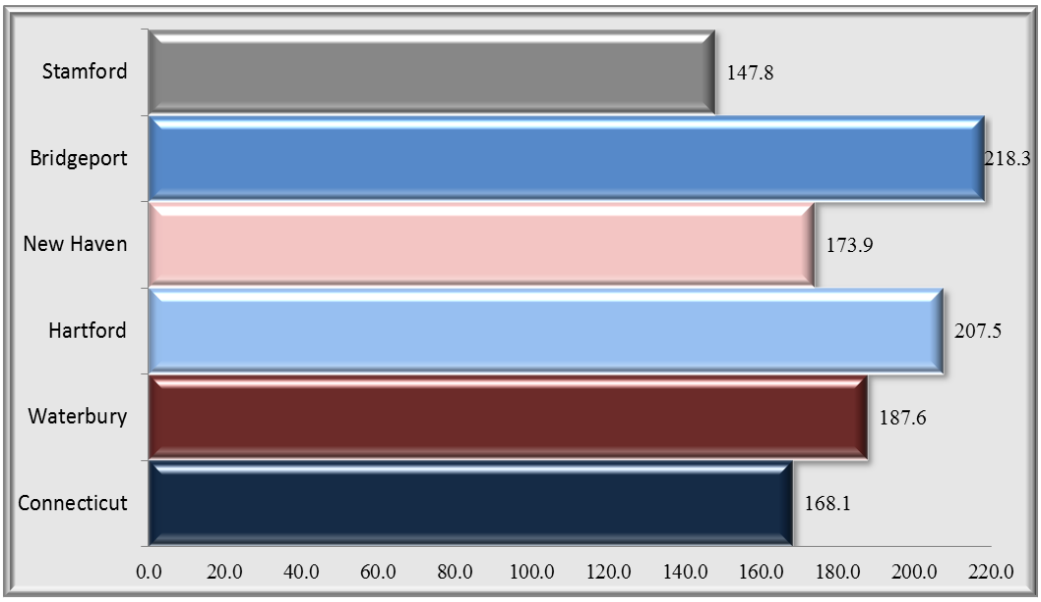


Figure 8. Deaths due to diseases of the heart per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

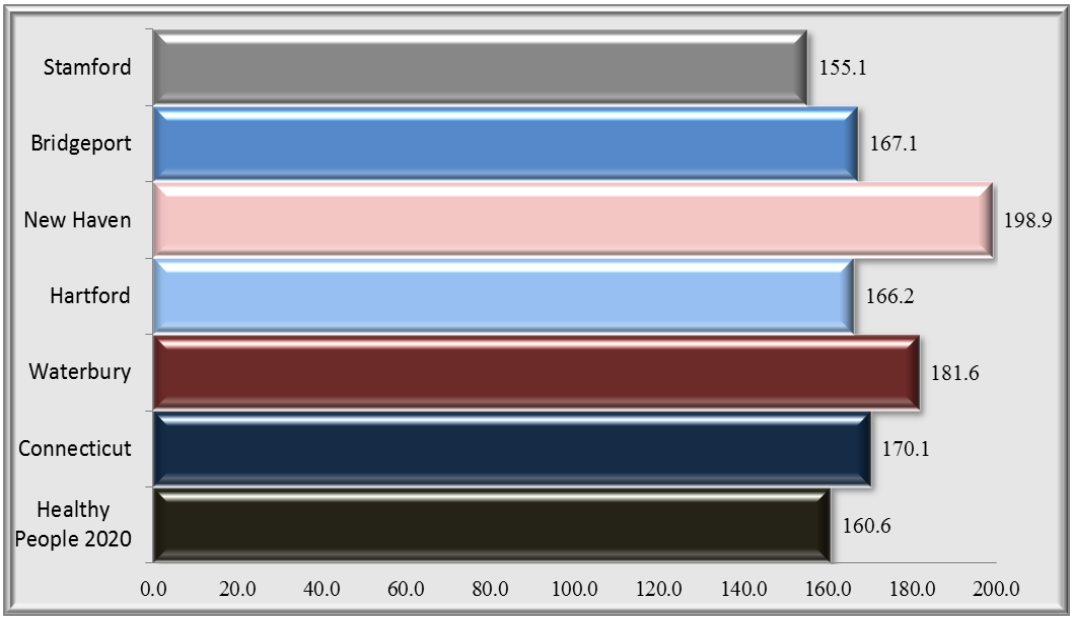


Figure 9. Deaths due to malignant neoplasms (cancer) per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011; Healthy People 2020, 2012;
Connecticut Department of Public Health, n.d.

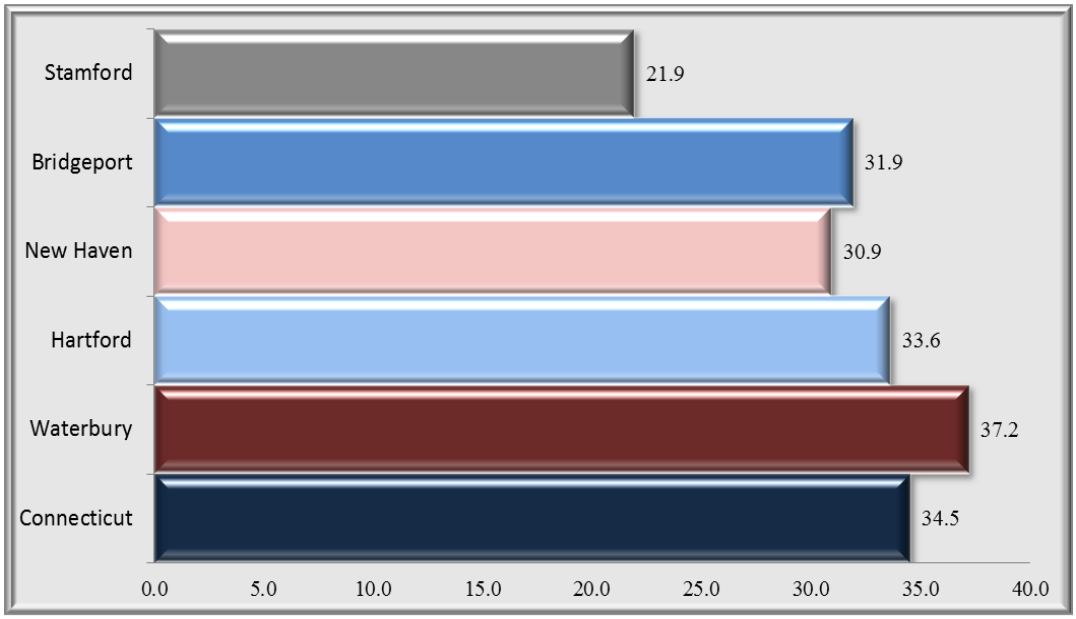


Figure 10. Deaths due to chronic lower respiratory disease per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

Maternal & Infant Health

The birth rate per 1,000 in Waterbury (15.7) is higher when compared to Connecticut (11.0), but similar to or lower than peer cities. Of the births that occur, 4.9% are to mothers less than 18 years of age and 14.5% are to mothers less than 20 years of age. These percentages are higher than what is seen across Connecticut (2.0% and 6.8% respectively) and all peer cities, excepting Hartford. The majority of teenage births are to mothers of Black and/or Hispanic race/ethnicity. Overall, the findings for teenage birth for the most recent year of data are negative, but births to teenagers less than 18 years of age have been trending downwards since 2005 (Connecticut Department of Public Health, 2011).

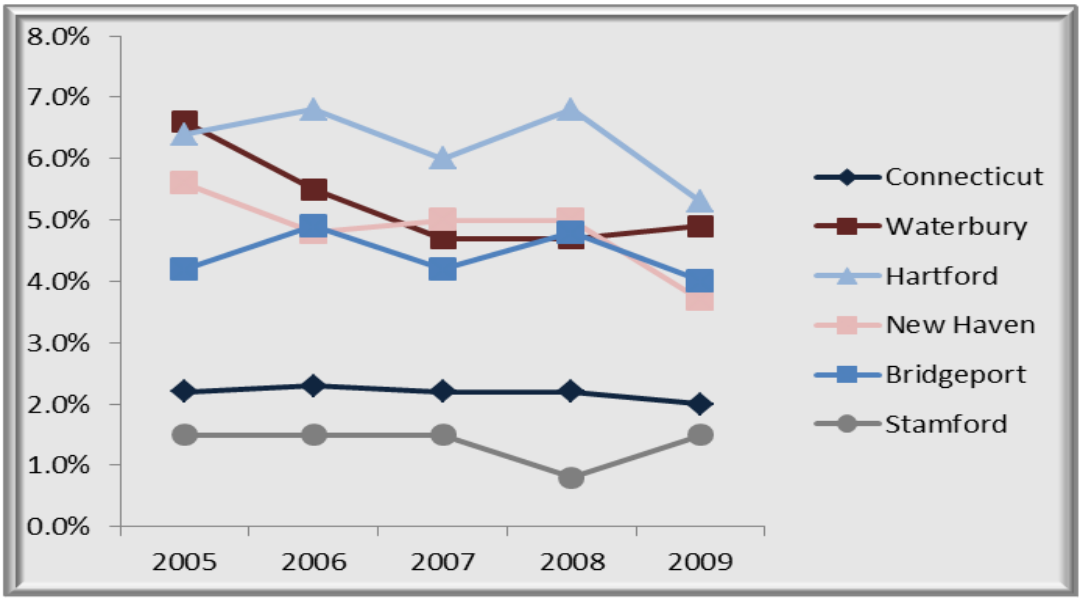


Figure 11. Births to teenagers less than 18 years, 2005 - 2009
Source: Connecticut Department of Public Health, 2007 - 2011

A total of 16 infant deaths occurred in Waterbury for a rate of 9.5 per 1,000 live births. This is higher when compared to Connecticut (5.6) and the Healthy People 2020 goal (6.0). The majority of infant deaths was among White infants (11 deaths, rate of 8.6) and occurred in the neonatal phase (within the first 27 days after birth). Seven Hispanic infant deaths also occurred in Waterbury for a rate of 10.4. This compares to a rate of 7.1 across all of Connecticut. In general, infant mortality has trended upwards in Waterbury since 2005 (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Related to infant mortality is birth weight. The percentage of infants born with low birth weight in Waterbury (10.0%) is higher when compared to Connecticut (8.1%), the Healthy People 2020 goal (7.8%), and every peer city except Hartford (10.5%). In particular, the percentage of Black infants born with low birth weight (14.6%) and very low birth weight (4.1%) is notably higher compared to Connecticut (12.0%; 3.2%) and all peer cities. Low birth weight has been on the rise in Waterbury since 2005, particularly for Black infants (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Despite primarily negative findings related to teenage birth, infant mortality, and birth weight, Waterbury mothers are more likely to receive adequate and intensive prenatal care than mothers across Connecticut. This is true for mothers of White, Black, and Hispanic race/ethnicity. Mothers receiving late or no prenatal care has been on the decline in Waterbury since 2005 (Connecticut Department of Public Health, 2011).

Sexually Transmitted Illnesses

Sexually transmitted illness rates per 100,000 are notably higher in Waterbury than in Connecticut, particularly for chlamydia and gonorrhea. The chlamydia rate is 720.5 in Waterbury compared to 344.9 in Connecticut and the gonorrhea rate is 225.9 in Waterbury compared to 72.6 in Connecticut. The Waterbury rates are more favorable compared to peer cities. The chlamydia rate alone is as high as 1,220.3 in New Haven and 1,513.8 in Hartford (Connecticut Department of Public Health, n.d.). The following chart illustrates this difference.

Table 3. Sexually Transmitted Illness Cases per 100,000 (2009, 2010)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
HIV	11.4	17.2	54.5	31.6	33.3	11.4
Gonorrhea	72.6	225.9	403.0	363.3	239.6	37.2
Chlamydia	344.9	720.5	1,513.8	1,220.3	863.8	268.5
Primary/Secondary Syphilis	1.8	1.9	6.4	3.2	4.4	2.5

Sources: Connecticut Department of Public Health, n.d.

[a] All statistics represent 2009 data with the exception of HIV, which represents 2010 data

Mental Health Statistics

The suicide rate is considered to be an indicator of the mental health status of an area. The suicide rate per 100,000 in Waterbury is 8.6, which meets the Healthy People 2020 goal of 10.2, but is higher than Connecticut (7.8) and all peer cities (5.5 – 8.4). The suicide rate is a negative finding, but it should not be considered an all-encompassing indication of the mental health status of Waterbury. Additional indicators from the household telephone survey, focus groups, and key informant interviews should be considered for a more comprehensive understanding (Connecticut Department of Public Health, n.d. & Healthy People 2020, 2012).

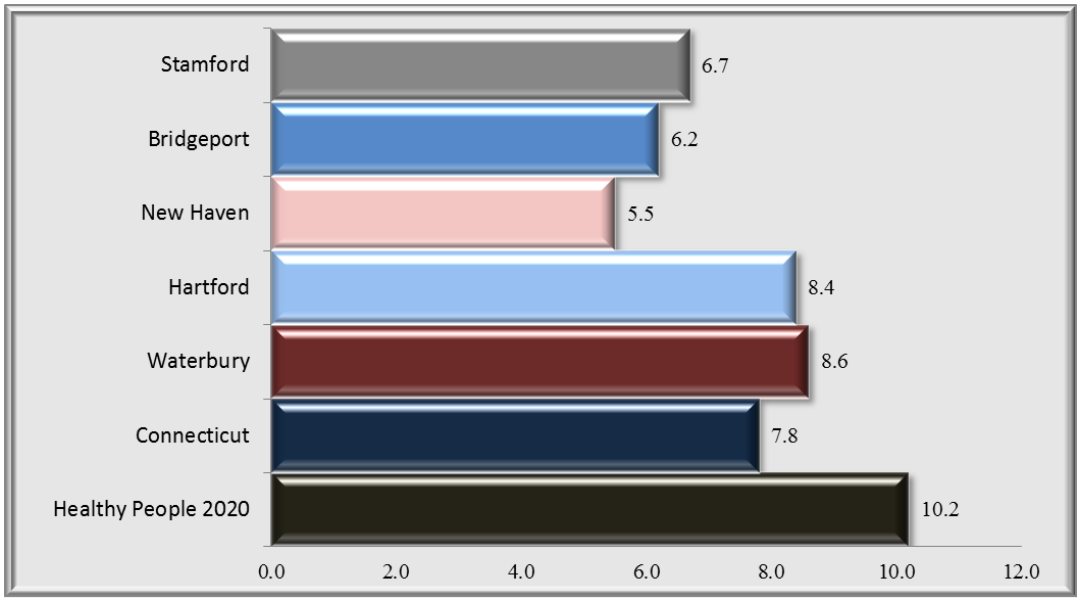


Figure 12. Suicide rates per 100,000, 2005 - 2009
Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Cancer Statistics

Cancer affects Waterbury residents at a rate of 484.3 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 484.3 is similar to or lower than that of Connecticut and peer cities. However, lung cancer disproportionately affects Waterbury residents at a rate of 81.2 compared to 74.3 across Connecticut and a range of 45.0 – 67.5 across all peer cities (Connecticut Department of Public Health, n.d.). The following chart depicts incidence rates for all reported cancer types.

Table 4. Cancer Incidence by Site per 100,000 (2007)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	155.6[a]	134.8[a]	83.7[a]	118.9[a]	107.8[a]	155.8[a]
Colorectal	51.3	51.3	33.7	37.9	43.2	65.0
Lung	74.3	81.2	45.0	55.7	64.4	67.5
Prostate	173.3[a]	76.2[a]	119.5[a]	116.8[a]	128.6[a]	178.8[a]
All sites	**561.6**	**484.3**	**335.6**	**445.4**	**443.3**	**534.3**

Source: Connecticut Department of Public Health, n.d.
[a]Rates based on 2010 population counts

In contrast to the overall cancer incidence rate, the overall cancer mortality rate is higher in Waterbury than in Connecticut and all but one peer city, New Haven. The mortality rate per 100,000 for all cancer types is 181.6 in Waterbury compared to 170.1 across Connecticut and a range of 155.1 – 167.1 across Bridgeport, Stamford, and Hartford. Lung cancer presents as an area of concern again as the mortality rate for this condition is notably higher in Waterbury

(53.5) compared to Connecticut (45.0), Healthy People 2020 (45.5), and all peer cities (36.5 – 44.1) (Connecticut Department of Public Health, n.d.).

Table 5. Cancer Mortality by Site per 100,000 (2005 - 2009)

	HP 2020	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	20.6	N/A	12.8	11.0	17.9	14.5	11.7
Colorectal	14.5	14.6	15.9	16.4	18.5	13.8	12.8
Lung	45.5	45.0	53.5	42.2	44.1	43.3	36.5
Prostate	21.2	N/A	7.7	8.9	11.8	7.2	9.1
Skin	N/A	2.6	N/A	N/A	N/A	N/A	N/A
All sites	160.6	170.1	181.6	166.2	198.9	167.1	155.1

Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Environmental Health Statistics

The environment that residents live, work, and play in can have a profound impact on their health. An indicator of the environmental health of an area is the prevalence of asthma. In Waterbury, the rate per 100,000 for emergency department visits due to asthma is 144.0 in adults 18 years and over and 197.3 in children under 18 years. This is notably higher than Connecticut's rates for adults and children (44.7 and 61.3 respectively) and most peer cities. Among adults in Waterbury, females, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma. Among children in Waterbury, males, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma (Connecticut Department of Public Health, 2009).

Table 6. Emergency Department Visits due to Asthma per 10,000 (2001 – 2005)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Population 18 +	44.7	144.0	182.8	108.8	126.7	41.5
Population <18	61.3	197.3	241.7	213.8	165.9	80.8

Source: Connecticut Department of Public Health, 2009

Another indicator of the environmental health of an area is the presence of food deserts, which are defined by Census tracts. Food deserts are areas that have little or no access to fully-stocked grocery stores that offer fresh, healthy, and affordable foods. In Waterbury, a number of census tracts have large populations living in food deserts. However, census tract 9009352400 is of particular concern. It has the highest percentage of residents living in a food desert across four out of the five reported categories (United States Department of Agriculture, 2010).

Table 7. Food Deserts by Census Tracts in Waterbury, Connecticut (2012)

	Population with low access to nutritious food sources	Population with low income and low access	Population 0-17 years with low access	Population 65+ years with low access	Population with no vehicle and low access
9009352400	100.0%	12.7%	31.6%	9.7%	16.4%
9009352300	21.3%	2.5%	5.2%	2.5%	3.4%
9009352200	55.1%	18.5%	24.2%	2.9%	14.2%
9009352100	33.7%	5.4%	9.5%	4.7%	3.6%
9009351800	57.7%	3.6%	10.8%	9.5%	3.7%
9009351500	45.9%	5.6%	11.7%	7.4%	7.0%
9009352800	33.4%	2.8%	11.4%	2.4%	4.3%

Source: United States Department of Agriculture, 2010

Secondary Data Profile Summary of Findings

The secondary data profile provided valuable context regarding how socioeconomic factors like income, education levels, and housing may influence local health outcomes. In Waterbury, the median income for households and families is higher; fewer residents live in poverty when compared to most peer cities. Residents are also less likely to rely on social assistance programs like Medicaid and State Administered General Assistance medical. In terms of health outcomes, Waterbury has lower rates of stroke mortality and sexually transmitted illness incidence. Waterbury has a number of strengths and assets, but it also has some areas to improve upon. In particular, Waterbury residents have more respiratory health issues and issues related to maternal and child health. In relation to respiratory health, residents are more likely to have visited an emergency department for asthma complications and to have died from lung cancer and chronic lower respiratory disease. Related to maternal and child health, the infant mortality rate is higher, infants are more likely to be born with low or very low births weight, and the number of teenage pregnancies is higher. Additional areas of concern in Waterbury are the suicide rate and food deserts, particularly in census tract 9009352400.

HOUSEHOLD TELEPHONE SURVEY OVERVIEW

Background

A statistical Household Telephone Survey was conducted based on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national initiative, conducted annually at the state level. The survey assesses self-reported health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

For the Waterbury study, trained interviewers conducted telephone interviews between May and June 2013 by trained interviewers. Participants were randomly selected for participation based on a statistically valid sampling frame that included landline and cell phone telephone numbers. Only respondents who were at least 18 years of age and lived in a private residence were included in the study. A total of 1,121 individuals who reside within specific Zip codes served by the Greater Waterbury Health Improvement Partnership were interviewed by telephone. Select participant demographics are included in Appendix C.

The customized survey tool consisted of approximately 100 factors selected from BRFSS tool. A few customized questions were added to gather information about health issues specific to the service area. Depending upon interviewees' responses, interviews ranged from approximately 15 to 30 minutes in length.

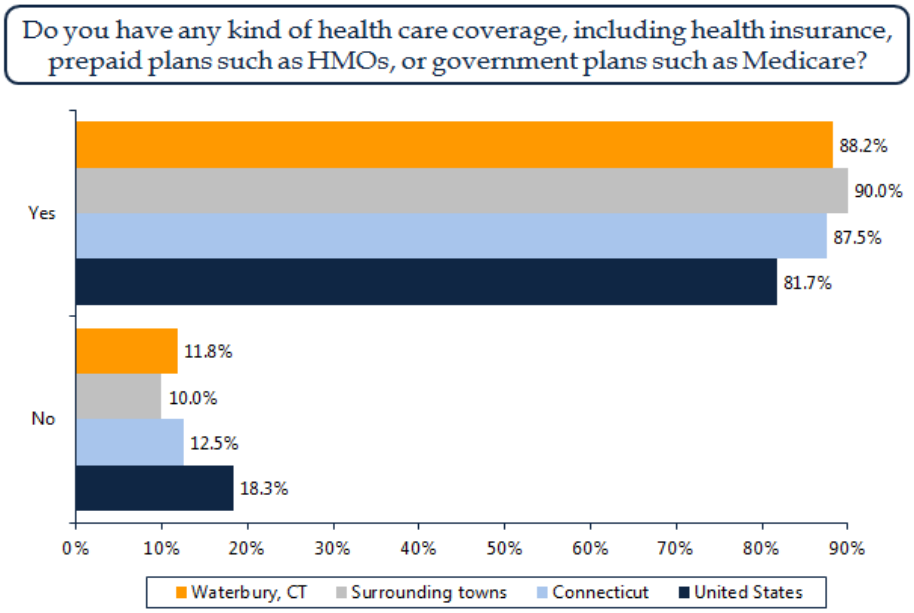
Statistical considerations for the study can be found in Appendix B. The following section provides a summary of the Household Telephone Survey results. A full report of the Household Telephone Survey results is available in a separate document.

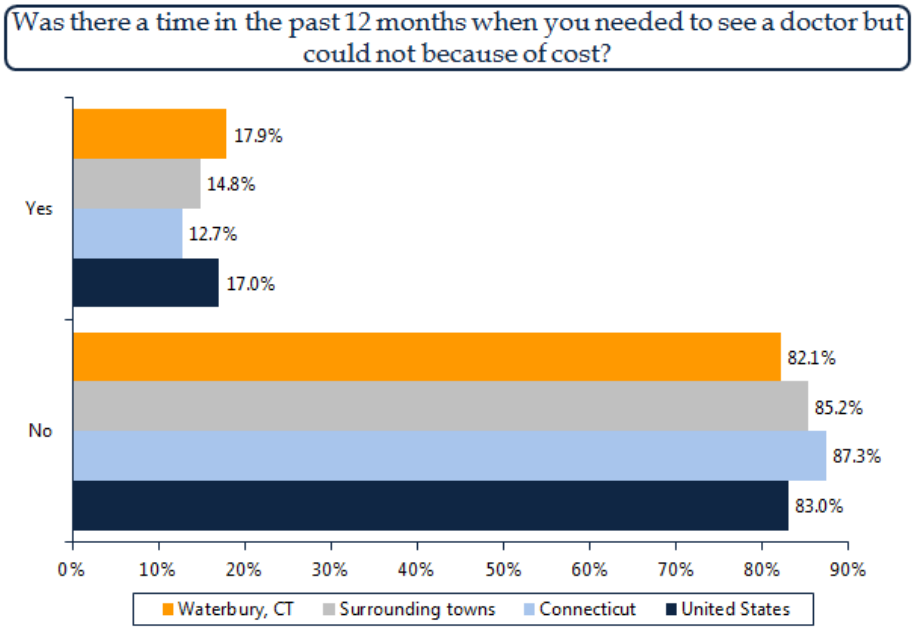
Household Telephone Survey Key Findings

The following section provides an overview of key findings from the Household Telephone Survey including highlights of important health indicators and health disparities.

Access to Health Care

Overall, residents of Waterbury are just as likely or more likely to have health care coverage (88.2%) and at least one person who they think of as their personal doctor or health care provider (84.1%) when compared to the state (87.5%; 85.2%) and the nation (81.7%; 78.0%). Local residents are also more likely to have received a routine checkup within the past year (76.6%) compared to the state (70.4%) and the nation (66.9%). Despite primarily positive findings regarding health insurance and access to primary care, residents of Waterbury still cite the cost of care as a barrier. Nearly 18% of respondents said that there was a time in the past 12 months when they needed to see a doctor but could not because of cost. This may be an indicator that out-of-pocket expenses that are not covered by insurance (e.g. copays) are preventing residents from seeking care when they need it.

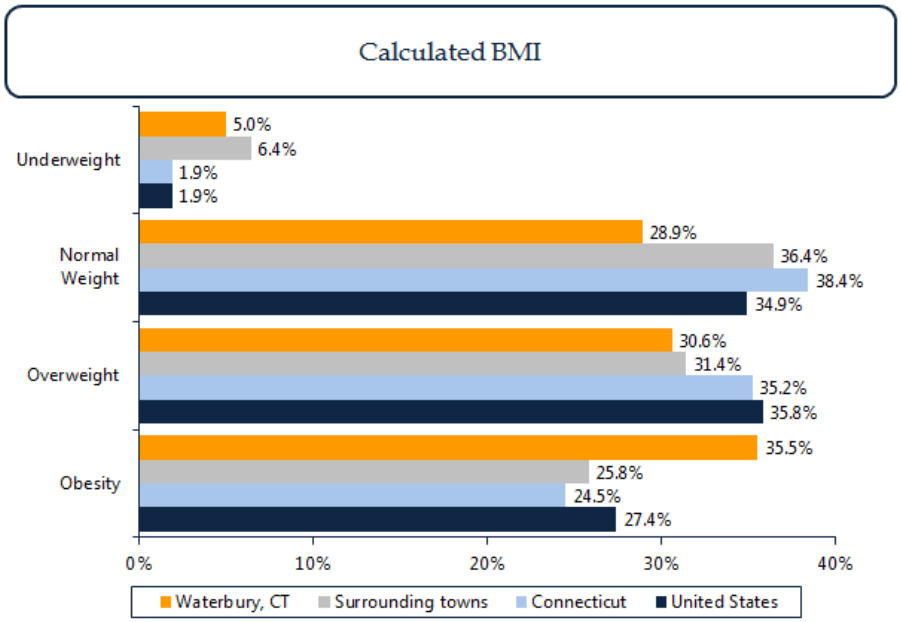




Health Risk Factors

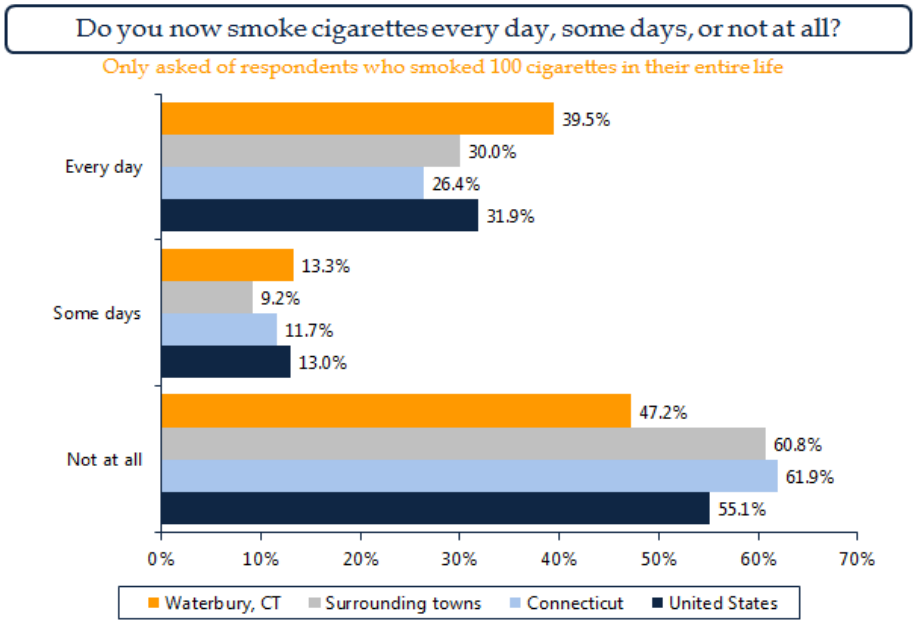
Obesity & Physical Activity

Obesity and its connection to serious medical conditions has become a national concern. In the latest BRFSS study, 63.2% of the nation and 59.7% of Connecticut was considered overweight or obese. Waterbury surpasses both with 66.1% of respondents considered overweight or obese and 35.5% considered obese. In addition, fewer respondents (68.9%) reported engaging in physical activity during the past month compared to the state (74.5%) and the nation (74.3%).

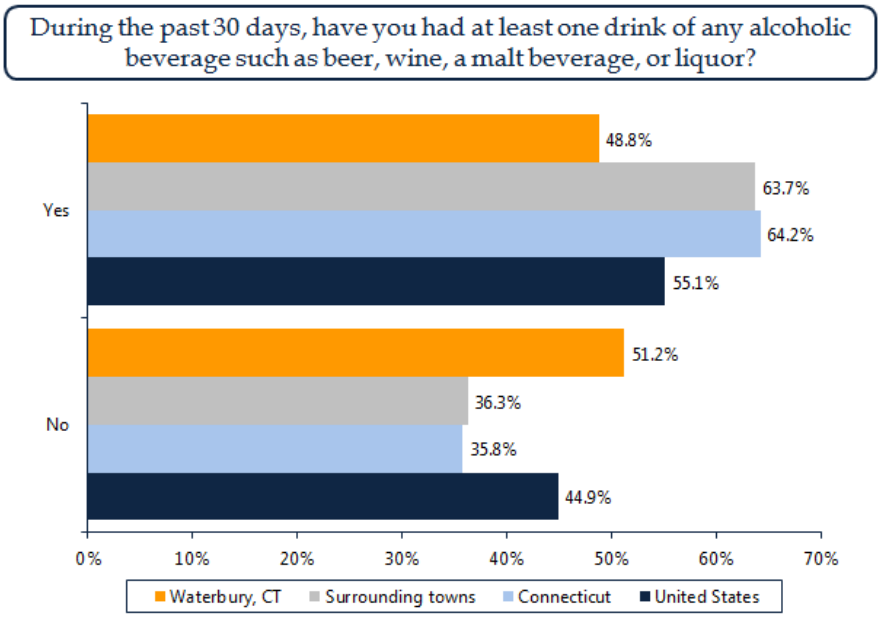


Tobacco & Alcohol Use

Tobacco use is a concern in Waterbury for both the proportion of residents who initiate smoking and the proportion who continue to smoke on a daily basis. More than half (51.1%) of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 45.0% across the state and 44.8% across the nation. In addition, more than half (52.8%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (38.1%) and the nation (44.9%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months.



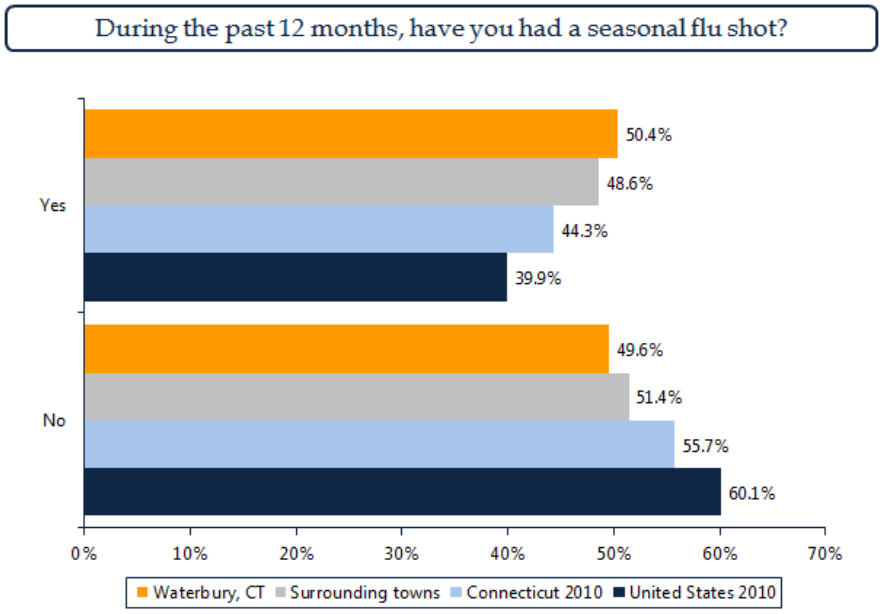
Alcohol use and abuse is not as prevalent. Only 48.8% of respondents had an alcoholic beverage during the past 30 days compared to 64.2% across Connecticut and 55.1% across the nation. Of the individuals who did consume alcohol, fewer did so on a daily basis or participated in binge drinking, and more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



Preventive Health Practices

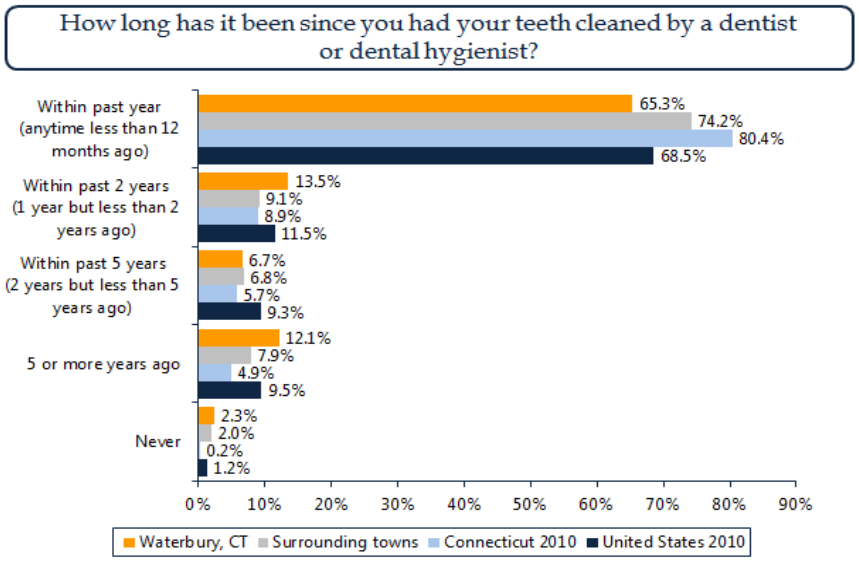
Immunizations

A positive finding among Waterbury respondents is the prevalence of immunizations. In the past 12 months, 51.8% of respondents received a flu vaccine either as a shot or a nasal spray compared to 45.2% in Connecticut and 41.3% in the nation. In addition, 35.5% received a pneumonia shot compared to 30.9% in Connecticut and 30.6% in the nation.

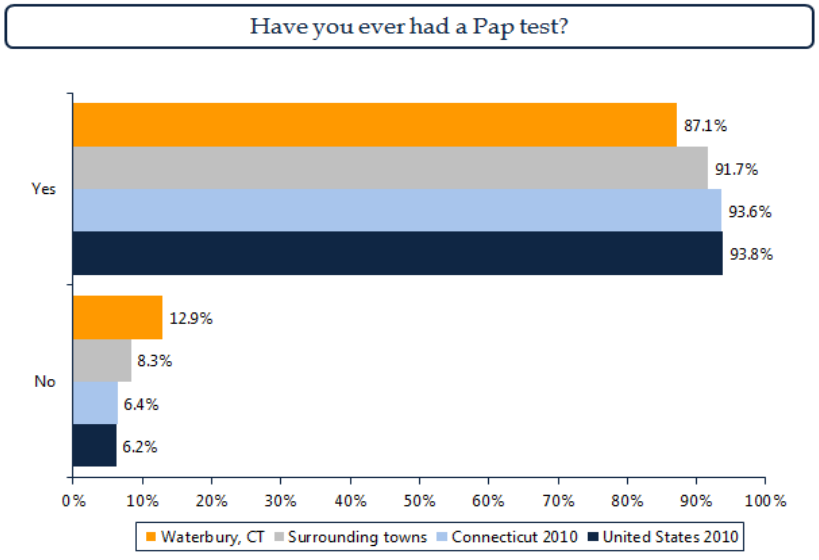


Screenings

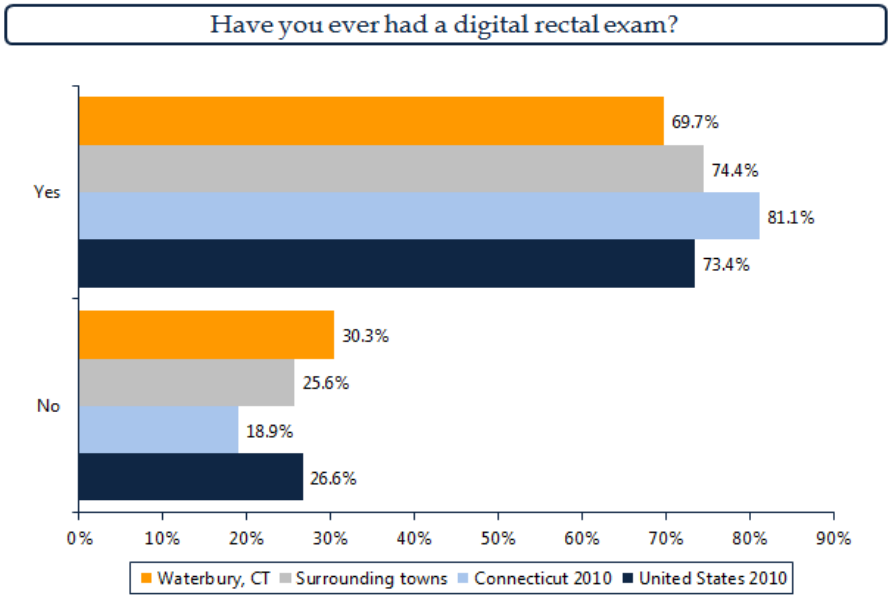
In general, Waterbury residents are less likely to engage in preventative oral health practices. Only 60.8% of respondents visited a dentist or a dental clinic within the past year. This is consistent with the nation (68.1%), but notably lower when compared to Connecticut (80.6%). Waterbury respondents are also less likely to have had their teeth cleaned (65.3%) within the past year when compared to both the state (80.4%) and the nation (68.5%).



Female preventative screenings are also less prevalent among Waterbury residents. Women are less likely to have ever received a mammogram, clinical breast exam, or Pap test when compared to women across Connecticut and the nation. The percentage of Waterbury women receiving a Pap test is of particular concern as only 87.1% have ever had one compared to 93.6% in Connecticut and 93.8% in the nation. The percentage of women receiving clinical breast exams (87.8%) is also concerning when compared to all of Connecticut (92.4%).



Men ages 39 and older have a greater risk for prostate cancer and should receive regular diagnostic screenings. Male respondents in Waterbury are more likely to have had one of the suggested screenings, a prostate-specific antigen test (57.5%), when compared to men across the nation (51.1%). However, they are less likely to have the second suggested screening, a digital rectal exam (69.7%), when compared to men across Connecticut (81.1%) and the nation (73.4%). In addition, of the men who have had a digital rectal exam, fewer had it within the past year. This is a potential health concern since male respondents in Waterbury are more likely to have prostate cancer (6.0%) when compared to the nation (3.5%).



Colorectal cancer can be screened for through home blood stool tests and sigmoidoscopies/ colonoscopies. Waterbury respondents are slightly more likely to have had a sigmoidoscopy/ colonoscopy when compared to the nation, but notably less likely to have had a home blood stool test (27.7%) when compared to the nation (45.4%). Of those respondents who have had a home blood stool test, a large proportion last had one five or more years ago (35.0%).

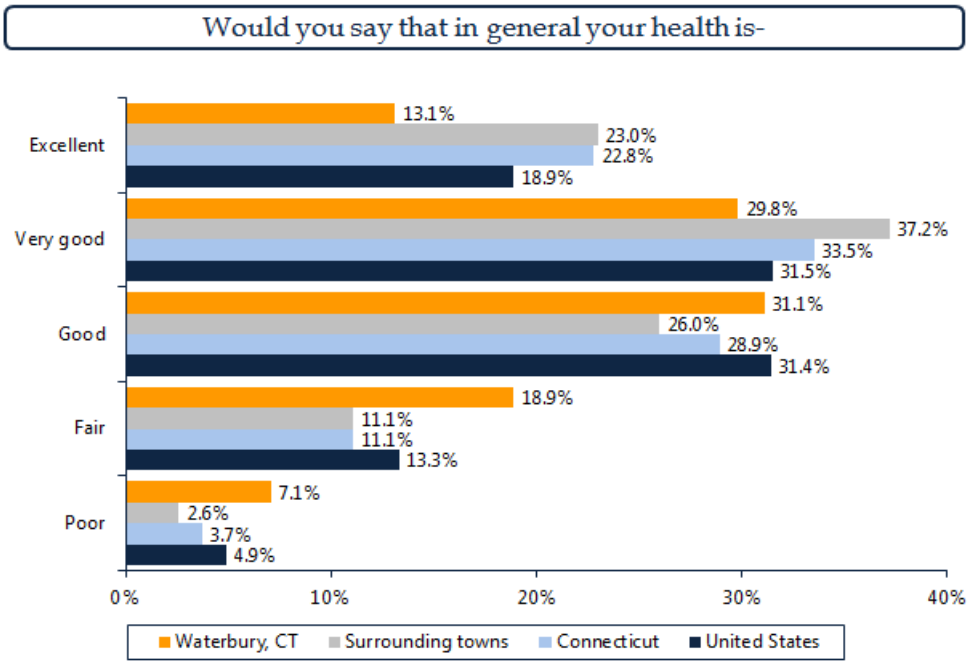
Residents in Waterbury are more likely to have been tested for HIV (55.7%) when compared to residents across Connecticut (36.7%) and the nation (37.4%). By itself, this is a positive finding. However, additional data suggests that a possible reason for higher screening rates is the prevalence of high risk behaviors. Approximately 7% of Waterbury respondents said that high risk situations like intravenous drug use and sexually transmitted diseases apply to them. This compares to 3.6% across Connecticut and 3.8% across the nation.

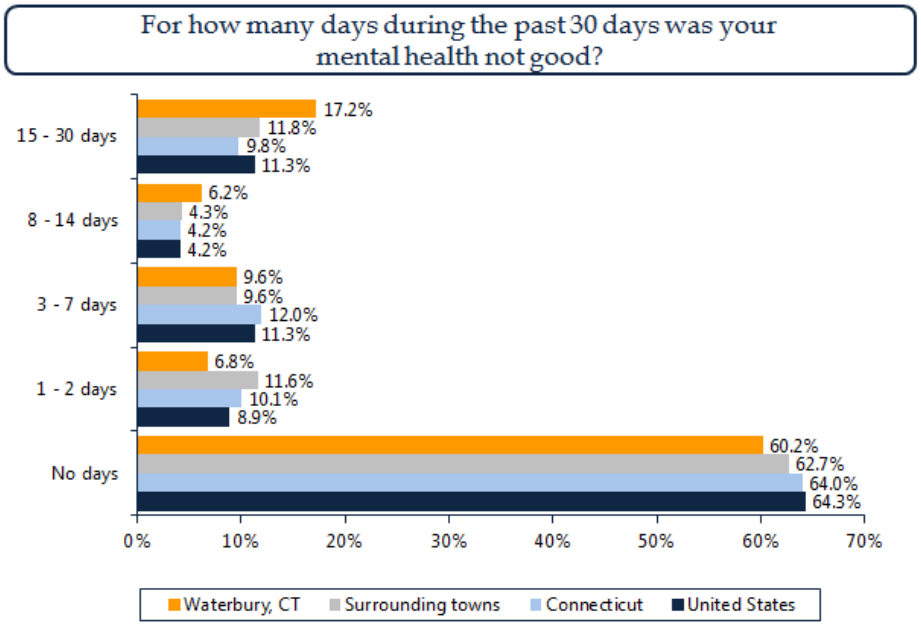
Health Status & Chronic Health Issues

Physical & Mental Health

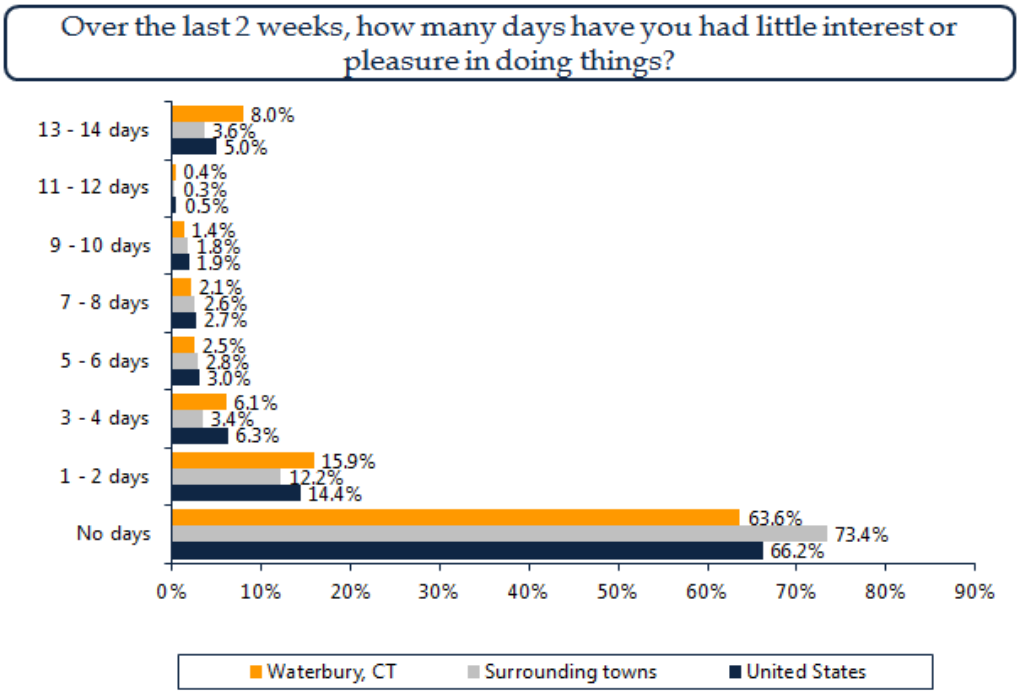
Residents of Waterbury are more likely to report having fair or poor health in general. Only 13.1% of respondents said that their health was excellent, compared to Connecticut (22.8%) and

the nation (18.9%). In addition, during the past 30 days, 40.8% of respondents said that they had at least one day of poor physical health and 39.8% said that they had at least one day of poor mental health. Of particular concern is the 17.2% of respondents who said that they had 15 – 30 days of poor mental health during the past 30 days. This compares to 9.8% across Connecticut and 11.3% across the nation. The combination of poor physical and mental health days kept 45.3% of respondents from doing their usual activities on at least one of the past 30 days.





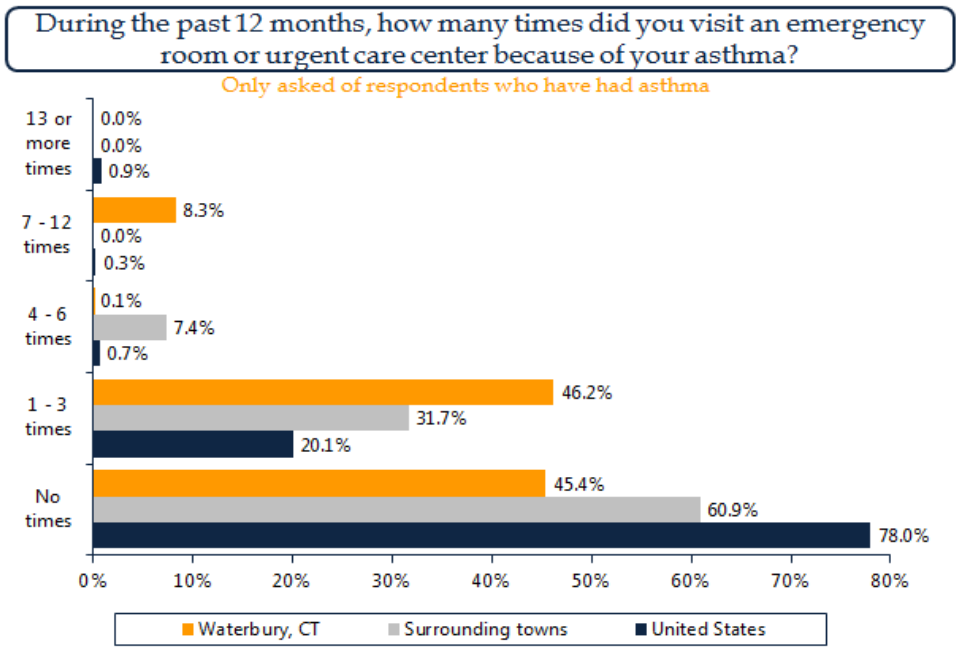
In addition to having more days of poor mental health, Waterbury respondents are more likely to have been diagnosed with an anxiety disorder and to have felt depressed and had little interest in doing things. The percentage of Waterbury respondents who have been diagnosed with an anxiety disorder is 19.7%. This compares to 16.7% across the nation. Over the last two weeks, 36.4% of respondents had little interest or pleasure in doing things and 34.3% felt down, depressed, or hopeless. A positive finding is that more respondents (16.4%) are taking medicine or receiving treatment from a health professional for their mental health condition when compared to the nation (12.5%).



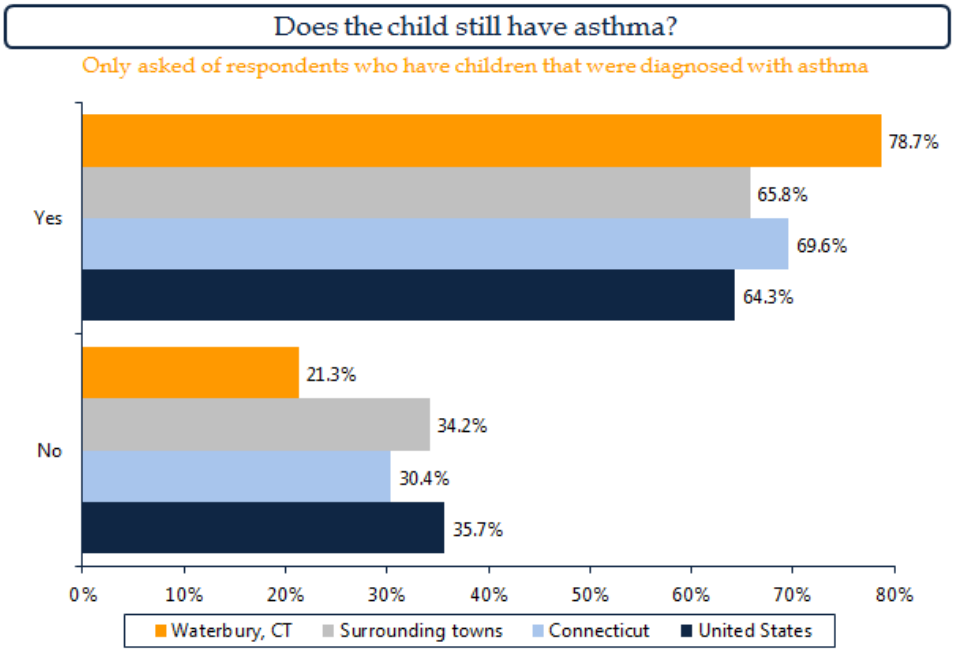
A contributing factor to the poor mental health status of Waterbury residents may be the proportion of residents who are acting as caregivers for friends or family members. During the past month, 27.1% of respondents provided caregiver services compared to 15.6% across Connecticut and 16.8% across the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

Chronic Health Issues

A number of chronic conditions are of concern in Waterbury, including asthma, cardiovascular disease, and diabetes. Approximately 22% of Waterbury respondents had been told that they have asthma. This compares to 14.8% in Connecticut and 13.5% in the nation. Additional data also suggests that asthmatics in Waterbury are not managing their condition as well. A higher proportion have had an asthma attack (59.2%) and visited an emergency room or urgent care center in the past year (54.6%) when compared to the nation (43.0%; 22.0%). A higher proportion has also been unable to carry out their usual activities because of their asthma (39.5%) when compared to the nation (23.8%).

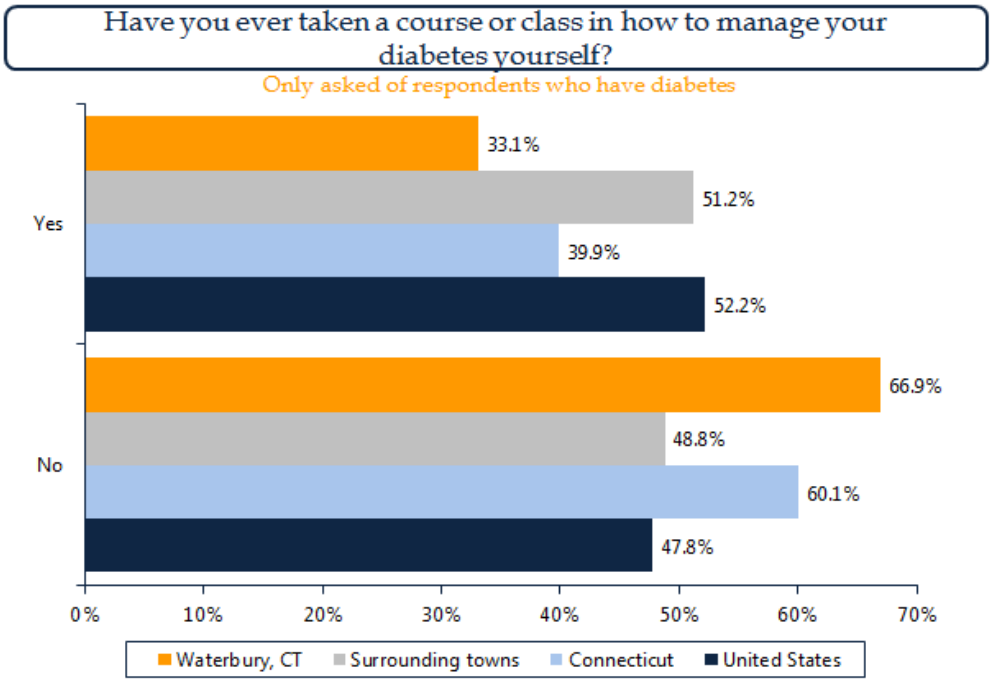


Children in Waterbury are also disproportionately affected by asthma. Slightly more than 21% have been diagnosed with asthma compared to 15.0% in Connecticut and 13.4% in the nation. They are also more likely to still have asthma (78.7%) when compared to Connecticut (69.6%) and the nation (64.3%).



Residents in Waterbury are more likely to have cardiovascular health issues like heart attacks (6.6%), angina or coronary heart disease (5.9%), and stroke (5.4%). A contributing factor (other than obesity and lack of physical activity) may be high blood pressure. A higher proportion of Waterbury residents have high blood pressure (33.6%) when compared to Connecticut (29.7%) and the nation (31.6%) and fewer are taking medicine for it.

A higher proportion of residents in Waterbury have been diagnosed with diabetes (14.8%) when compared to Connecticut (9.3%) and the nation (9.8%). This is a concern for the community in terms of prevention, but even more concerning is that diabetics in Waterbury are less likely to manage their condition. Fewer diabetics are taking insulin, checking their blood glucose levels on a daily basis, seeing a health professional for their condition, having a health professional conduct an A1C test or foot check, and attending self-management courses. Specifically, only 33.1% of diabetic respondents have taken a course in how to manage their diabetes compared to 39.9% of diabetics across Connecticut and 52.2% of diabetics across the nation.



Household Telephone Survey Summary of Findings

A number of areas of opportunity were identified through the household telephone survey. The first area was access to care. Residents are more likely to have trouble affording out-of-pocket expenses despite having equitable health insurance coverage. They are also less likely to receive preventive screenings related to oral health and women's health. The second area was chronic health conditions. Respiratory conditions presented as an issue with a higher proportion of residents saying that they and their children have asthma. A contributing factor to asthma rates may be the proportion of residents who smoke cigarettes. Cardiovascular disease and diabetes

also presented as concerns among residents. Contributing factors to these conditions may be the proportion of residents who are overweight or obese and have high blood pressure. The third area was the mental health status of Waterbury. Residents have more days of poor mental health, are more likely to experience depression and be diagnosed with an anxiety disorder.

FOCUS GROUPS OVERVIEW

Background

A total of six focus groups were held at various locations throughout Waterbury in February 2013. Two of the groups were conducted with health care providers associated with the two hospitals; four groups were conducted with members of neighborhood associations. Focus group topics addressed access to care, cultural competency, physical activity, nutrition/healthy eating habits, weight/obesity, and health information. Each session lasted approximately 90 minutes and was facilitated by trained staff from Holleran.

Participants were recruited through the CHNA partners. In exchange for their participation, health care providers were given a $25 gift card; community members received $25 cash. Two discussion guides developed in consultation with the Greater Waterbury Health Improvement Partnership, were used to prompt discussion and guide the facilitation.

In total, 57 people participated in the focus groups. It is important to note that the results reflect the perceptions of a limited number of providers and community members and may not necessarily represent all providers and residents of Waterbury.

The following section provides a summary of the focus group discussions including key themes and select comments.

Health Care Provider Focus Groups Key Findings

Access to Care

Access to care was an area of shared concern among Saint Mary's and Waterbury Hospital physicians. Physicians agreed that the greatest barriers to accessing care in Waterbury are an inadequate number of physicians, particularly primary care physicians, and health insurance-related issues. The primary care shortage in Waterbury has prohibited patients from having assured and timely access to care, even if they are insured. Many patients with medical homes are still using the ED due to the limited hours of clinics and the overwhelming demand for limited appointment slots. Participants also pointed out that primary care physicians are the lowest paid providers and care for the most challenging payer mix.

Participants shared that low Medicaid reimbursements limit the number of patients that primary and specialty physicians are willing to see. One physician stated, "It costs us more to see the

patients than what we receive in reimbursement." Additional barriers to accessing care included a lack of awareness of available services among eligible patients, limited bilingual services for non-English speaking residents, transportation, and co-payments. Another physician stated, "Even residents with health insurance are financially stressed and don't follow through on their care due to copayment costs."

There was general consensus among providers that patients with mental and/or behavioral health issues are underserved. It is difficult for these patients to receive the care that they need because providers are hesitant to "take responsibility for them" and services are limited. Providers are reluctant to be the "physician of record." Other underserved populations included the seasonally insured, service industry workers, and minority populations.

Participants listed a number of resources for uninsured and underinsured residents. The Waterbury Health Access Program (WHAP) was seen as particularly successful in linking needy patients with volunteer physicians and insurance. Lack of funding could jeopardize the future of the program.

Key Health Issues and Challenges

Mental and behavioral health issues were seen as key health issues in the community. One physician suggested that there was "widespread emotional despair" within the city. Other concerns were that elderly patients suffered from dementia, late-stage breast cancer diagnoses, and obesity.

Related to obesity, participants saw a number of challenges for residents trying to stay physically fit and eat a healthy diet. Fresh fruits are expensive and not widely available following recent closings of several supermarkets. An increase in farmers' markets was seen as a positive development. Other barriers included residents' awareness of healthy diets, as well as their willingness to dedicate resources to costly fruits and vegetables (over less expensive fast food alternatives). Compounding challenges to maintaining health, a lack of accessible, safe recreational areas was noted.

Participants provided several recommendations for improving the health of the community. Better patient navigation, extended clinic hours to serve residents instead of the ED, and higher reimbursement for Medicaid patients, were among recommendations provided. Participants agreed that mental health treatment options also needed to be expanded. Investments to improve poor economic conditions in the city needed to continue.

Provider Resources

Providers agreed that insurance-related issues are one of the top obstacles that they face in providing care. The amount of paperwork required by each plan burdens medical offices and takes away from direct patient care. Providers also stated that a merger between the two hospitals in Waterbury would create more seamless care and financial stability that would allow for more modern technology.

Local health departments were viewed as helping to meet the needs of the Waterbury community; however, most participants were not aware of specific activities. The general consensus was that more support from entities across the community was needed. One participant stated, "It comes down to shared responsibility. Everyone needs to take a part."

Community Resident Focus Groups Key Findings

Access to Care

A number of issues were identified by community residents as barring people from accessing health care. Many issues were centered on the cost of care. Participants identified lack of health insurance, the cost of copayments and medications, and increasing premiums and deductibles, specifically. They also expressed concern that Husky Care (Medicaid) was often not accepted by providers and that people were "looked down upon" for having it. Other issues included transportation, clinic hours of operation, language barriers, lack of awareness of services, and legal status. Participants stated that it can "take all day" to see the doctor due to the limited number of bus stops and long wait times between rides. They also stated that the only place to receive care after hours was the ED since clinics and private medical offices were closed. Hispanics/Latinos and Albanian residents were viewed as most impacted by language barriers.

Participants felt that a number of populations within the community were not being adequately served by local health services. These included African Americans, Hispanics/Latinos, single mothers with children, the homeless, mentally ill residents, seniors, and teens. Participants explained that for those seniors who need assistance with Activities of Daily Living (ADL), traveling to the Veteran's Administration Hospital in West Haven (45 minutes away) is a burden. They also expressed that teens are often not able to afford medication and are struggling with issues like sexually transmitted diseases. Resources identified that cared for underserved populations included hospital EDs, health clinics, Planned Parenthood, and the Malta House of Care van.

Dental care and mental health care were viewed as lacking services in the community. Participants agreed that dental care is largely unavailable without insurance. There was general consensus that there was "no place to go" for mental health care services. One person stated, "You have to commit a crime to get mental health care."

Key Health Issues and Challenges

More than 10 health issues were identified as major concerns in the community. Among the issues, mental and behavioral health issues were mentioned several times. In particular, participants noted wide-spread abuse of medicines like Nyquil and addictions to pain medication. Several factors were seen as contributing to addictive behavior including long delays in getting appointments and automatic refilling of pain medication prescriptions. Participants also noted tobacco use as a major concern. They observed that "Everyone smokes

cigarettes." An increased popularity of small cigars due to the lower cost compared to cigarettes was noted.

Participants noted a number of challenges for people in the community trying to stay physically fit and eat healthier. There was broad agreement that Waterbury does not offer adequate opportunity for physical activity. Comments included: "There are no safe parks." "Sidewalks are not in good condition." "Streets are of an old design; they are not wheelchair or stroller friendly." "There are no bike trails." "Today's parks have crooked slides and broken sprinklers." "There are syringes on the ground."

Programs that are available for recreation have a cost associated with them. Two organizations, the Police Athletic League (PAL) and the YMCA, were seen as positive entities, although both have fees for participation. Participants agreed that fresh fruits and vegetables were available year-round, but that barriers like cost, transportation, and location keep residents from accessing them widely. The farmer's market was seen as a step in the right direction; however, one participant said "You have to fight your way through panhandlers and the homeless to shop there." One solution was to increase the number of community gardens in Waterbury.

A number of weaknesses related to the socio-economic and physical environment of the community were identified. Participants stated that there was a lack of jobs in the area and that youth didn't have work opportunities. Poverty conditions often caused parents to "hop from apartment to apartment" to avoid paying rent, causing school transfers and disruption to children's education. Blight, littering, and poor school conditions were also concerns. One participant stated, "Residents are not invested in the areas where they live."

Community Aspirations & Capacity

Participants offered a number of suggestions for improving the health of the community. Specific examples included expanding access to care by "bringing back" the StayWell Health Center van; sponsoring free dental clinics; offering more health screenings and smoking cessation programs; and promoting on-going health education campaigns. Cleaning up the city park, improving the transportation system, sponsoring more community gardens, and providing safe and clean public restrooms in the downtown area were suggested to improve the city environment.

Participants urged community organizations to concentrate on the city as a whole and work to improve the socio-economic factors burdening residents. They also cited the need for more general counseling services and community mentors for the youth. Participants thought that efforts needed to be made to "instill more pride in the city" in an effort to encourage more community involvement and advocacy. Religious organizations were seen as untapped resource in these efforts.

Focus Group Summary of Findings

The focus group participants were grateful for the opportunity to share their thoughts and experiences; many expressed support for community-wide efforts to improve the health status of Waterbury. Identified community strengths included area healthcare providers, specifically the hospitals, health clinics, and local health departments. Areas of opportunity included expanding access to care for residents, availability of resources to improve physical activity and healthy eating, and concerns of blight and community investment.

KEY INFORMANT INTERVIEWS OVERVIEW

Background

An online survey was conducted among area "Key Informants." Key informants were defined as community stakeholders with expert knowledge including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders.

Holleran staff worked closely with the Greater Waterbury Health Improvement Partnership to identify key informant participants and to develop the Key Informant Survey Tool. Two-hundred and five (205) completed surveys were collected between February and April 2013. A listing of key informant participants can be found in Appendix D.

The questionnaire focused on gathering qualitative feedback regarding perceptions of community needs and strengths across three key domains:

- Key Health Issues
- Health Care Access
- Challenges & Solutions

It is important to note that the results reflect the perceptions of some community leaders, but may not necessarily represent all community representatives within Waterbury.

Key Informant Study Findings

Key Health Issues

The first section of the survey focused on the key health issues facing the community. Individuals were asked to select the top health issues that they perceived as being the most significant. The issues that were most frequently selected were:

1. Mental/Behavioral Health
2. Overweight/Obesity
3. Access to Health Care/Uninsured/Underinsured
4. Substance Abuse/ Alcohol Abuse
5. Heart Disease

The following table shows the breakdown of the percent of respondents who selected each health issue. Issues are ranked from top to bottom based on number of participants who selected the health issue as one of their top five issues. The first column depicts the total percentage of respondents that selected the health issue as one of their top five. Respondents were also asked of those health issues mentioned, which one issue is the most significant. The second column depicts the percentage of respondents that rated the issue as being the most significant of their top five.

Table 1: Ranking of Key Health Issues

Rank	Health issue	Percent of respondents who selected the issue	Percent of respondents who selected the issue as the most significant
1	Mental/Behavioral Health	78%	32%
2	Overweight/Obesity	66%	14%
3	Access to Health Care/ Uninsured/Underinsured	63%	26%
4	Substance Abuse/Alcohol Abuse	61%	7%
5	Heart Disease	42%	5%
6	Diabetes	41%	2%
7	Cancer	34%	7%
8	Caregiver Needs	30%	4%
9	Dental Health	21%	0%
10	Tobacco	20%	1%
11	Maternal/Infant Health	16%	1%
12	Stroke	11%	1%
13	Sexually Transmitted Diseases	7%	0%
14	HIV/AIDS	6%	1%

Figure 1 shows the key informant rankings of all the key health issues. The bar depicts the total percentage of respondents that ranked the issue in their top five.

"What are the top 5 health issues you see in your community?"

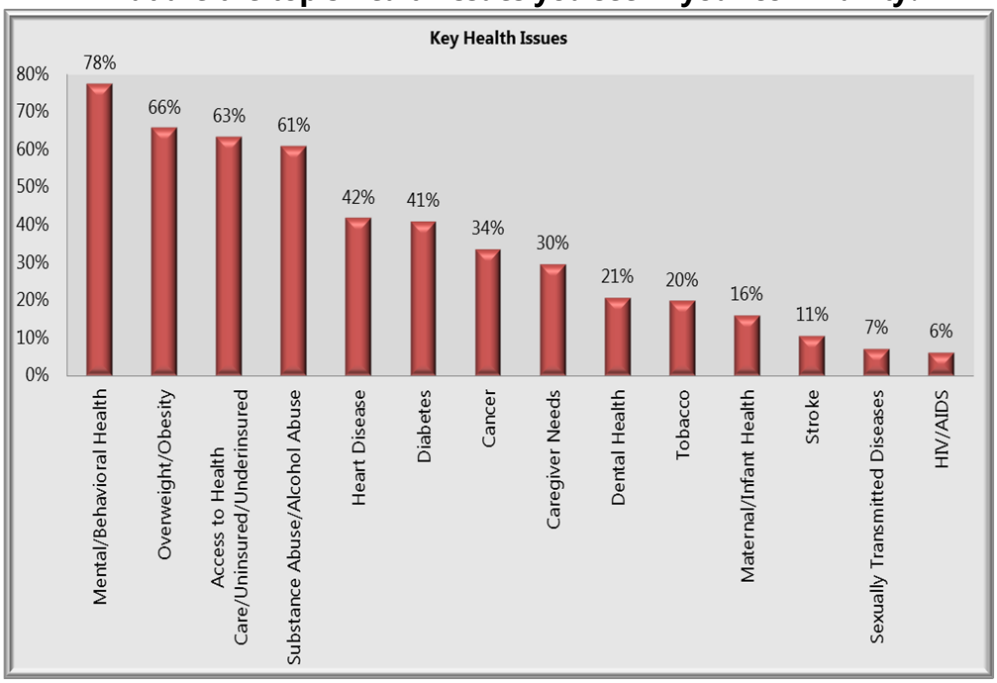


Figure 1: Ranking of key health issues

Health Care Access

Availability of Services

The second set of questions concerned the ability of local residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bilingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). The results are displayed in Table 2.

Health care access appears to be a significant issue in the community. As illustrated in Table 2, none of the informants strongly agree to any of the health care access factors. Most respondents 'Disagree', with community residents' ability to access care. Availability of mental/ behavioral health providers garnered the lowest mean responses (2.06), compared to the other factors.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access."

Table 2: Mean Responses for Health Care Access Factors

Factor	Mean Response	Corresponding Scale Response
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	3.19	Neither agree nor disagree
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	2.90	Disagree
Residents in the area are able to access a dentist when needed.	2.93	Disagree
There are a sufficient number of providers accepting Medicaid and medical assistance in the area.	2.33	Disagree
There are a sufficient number of bilingual providers in the area.	2.40	Disagree
There are a sufficient number of mental/ behavioral health providers in the area.	2.06	Disagree
Transportation for medical appointments is available to residents in the area when needed.	2.53	Disagree

Barriers to Health Care Access

After rating availability of health care services, the informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Inability to Pay Out-of-Pocket Expenses (co-pays, prescriptions, etc.)
- Lack of Health Insurance Coverage
- Inability to Navigate Health Care System

Table 3 shows the breakdown of the number and percent of respondents who selected each barrier. Barriers are ranked from top to bottom based on the frequency of participants who selected the barrier. The third column in the table depicts the percentage of respondents that rated the barrier as being the most significant facing the community.

"What are the most significant barriers that keep people in the community from accessing health care when they need it?"

Table 3: Ranking of Barriers to Health Care Access

Rank	Barrier to Health Care Access	Number of respondents who selected the issue	Percent of respondents who selected the issue	Percent of respondents who marked it as the most significant barrier
1	Inability to Pay Out of Pocket Expenses	151	80%	19%
2	Lack of Health Insurance Coverage	135	71%	20%
3	Inability to Navigate Health Care System	131	69%	26%
4	Lack of Transportation	107	57%	4%
5	Language/Cultural Barriers	86	46%	1%
6	Basic Needs Not Met (Food/Shelter)	80	42%	8%
7	Time Limitations	82	43%	3%
8	Availability of Providers/Appointments	80	42%	14%
9	Lack of Child Care	45	24%	1%
10	Lack of Trust	42	22%	2%

Figure 2 shows a graphical depiction of the frequency of selected barriers to health care access.

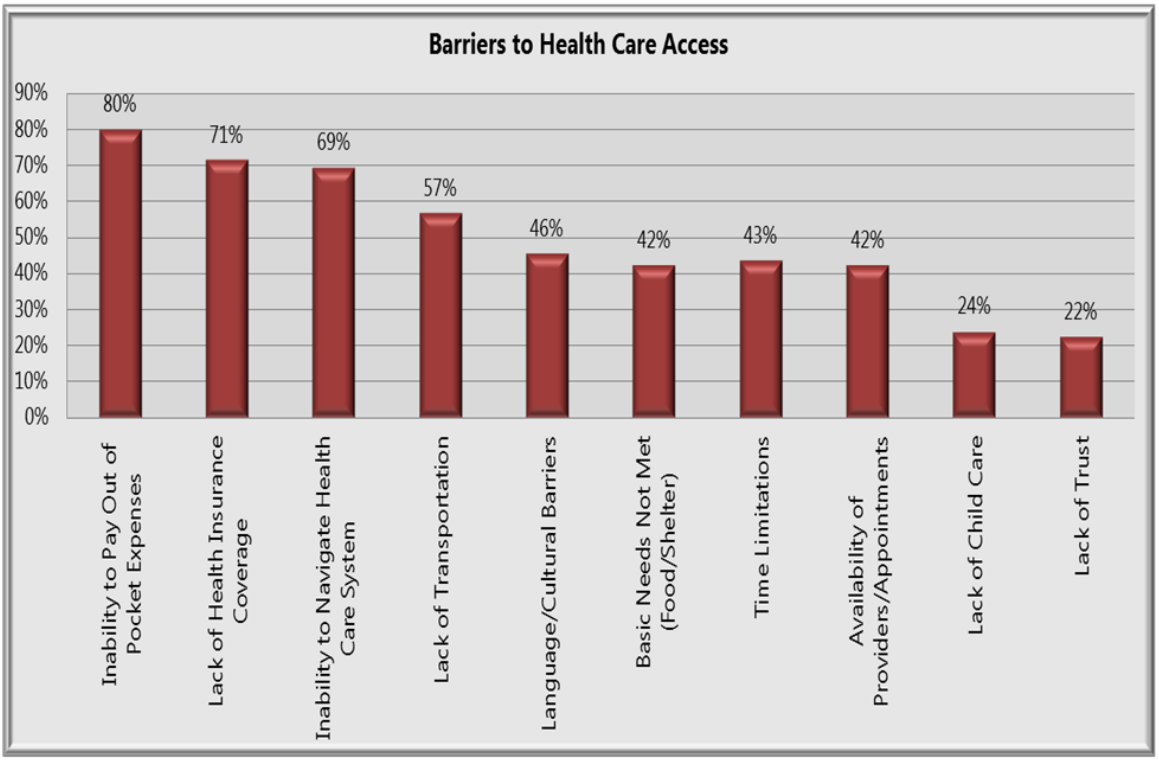


Figure 2: Ranking of barriers to health care access

Underserved Populations

Informants were then asked whether they thought there were specific populations who are not being adequately served by local health services. As seen in Figure 3, the majority of respondents (82%) indicated that there are underserved populations in the community.

"Are there specific populations in this community that you think are not being adequately served by local health services?"

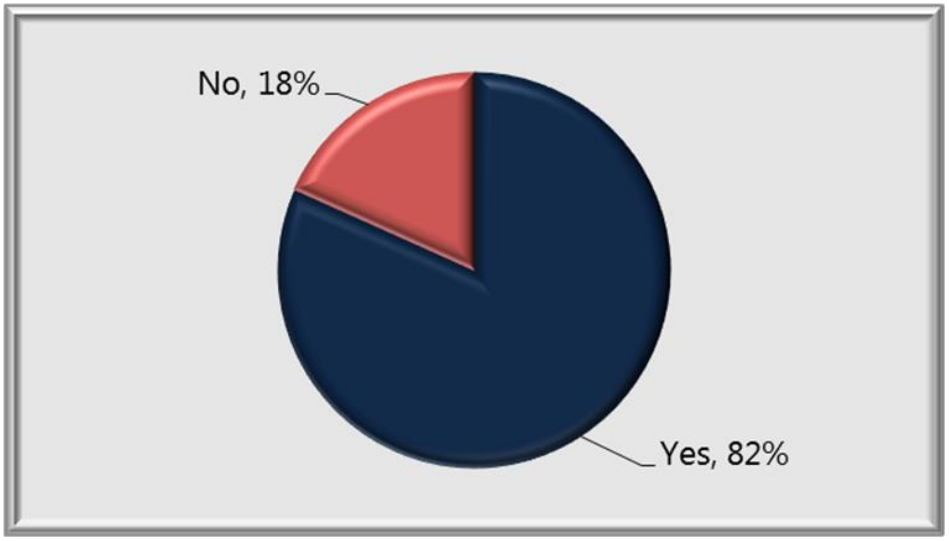


Figure 3: Key informant opinions regarding underserved populations

Those respondents were asked to identify which populations they thought were underserved. The results can be found in Table 4 below. Uninsured/underinsured and low-income/poor individuals were considered underserved populations along with homeless individuals and seniors/aging/elderly individuals. In addition, several respondents felt that racial/ethnic minorities and immigrant/refugee population were underserved.

Table 4: Underserved Populations

	Underserved population	Number of respondents selecting the population
1	Uninsured/Underinsured	98
2	Low-income/Poor	82
3	Homeless	64
4	Seniors/Aging/Elderly	41
5	Hispanic/Latino	35
6	Immigrant/Refugee	33
7	Black/African-American	31
8	Children/Youth	29
9	Disabled	28
10	Young Adults	22
11	Lower Middle Class	3
12	Mental Health/Addicts	1
13	Veterans	1
14	LGBT	1

Health Care for Uninsured/Underinsured

Next, the informants were asked to select where they think most uninsured and underinsured individuals go when they are in need of medical care. As shown in Figure 4, the majority of respondents (81%) indicated that uninsured and underinsured individuals go to the Hospital Emergency Department for medical care.

In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care?

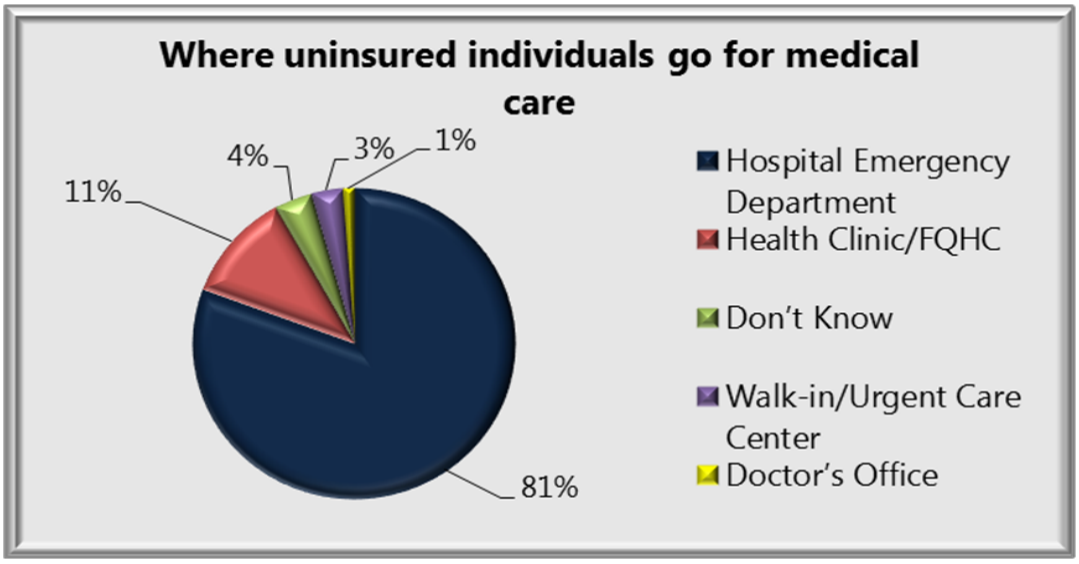


Figure 4: Key informant opinions of where uninsured individuals receive medical care

Resources Needed to Improve Access

Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many respondents indicated that free and low cost medical and dental care, and mental health services are needed. In addition, informants want to see more health education and outreach and more transportation/assisted transportation. Table 5 includes a listing of the resources mentioned ranked in order of the number of mentions.

Table 5: Listing of Resources Needed in the Community

Rank	Resources Needed	Number of Mentions
1	Free/Low Cost Dental Care	111
2	Mental Health Services	108
3	Free/Low Cost Medical Care	93
4	Health Education/Information/Outreach	78
5	Transportation/Assisted Transportation	69
6	Health Screenings	63
7	Bilingual Services	58
8	Prescription Assistance	58
9	Substance Abuse Services	52
10	Primary Care Providers	39
11	Medical Specialists	32
12	Free/Low Cost Dental Care	111

Challenges & Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community.

When asked what challenges people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort
- Education/Knowledge
- Chronic Conditions/Diseases
- Cultural Norms
- Environment/Safety

Next, key informants were asked "What recommendations or suggestions do you have to improve health and quality of life in the community?" Several major themes emerged from the comments including the following:

- Increased Awareness/Education/Community Outreach
- Increased Collaboration/Coordination
- Improved Access to Medical Care, Dental Care, and Mental Health Services
- Improved Access to Affordable Exercise and Nutrition Programs
- Need For Patient Navigation
- Enhanced Programs/Outreach for Youth and Seniors
- Enhanced Community Space

Key Informant Interviews Summary of Findings

Key informants acknowledged that mental/behavioral health, overweight/obesity, and access to care are the most significant health issues in the community. Related to access to care, informants agreed that residents do not have sufficient access to providers and experience a number of barriers in seeking care. In particular, they felt that residents are not able to see specialists, dentists, and mental/behavioral health providers when they need to. They also felt that there are not enough bilingual providers and providers accepting Medicaid and medical assistance. Additional barriers for residents seeking care are out-of-pocket expenses, lack of health insurance coverage, and the inability to navigate the health care system. Informants recommended a number of resources to improve access to care. Among these, free/low cost dental care, mental health services, and free/low cost medical care were cited the most.

Eighty-two percent of informants agreed that there are underserved populations living in Waterbury. Of these populations, they felt that the uninsured/underinsured, low-income/poor, and homeless are the most underserved. When seeking medical care, these populations were thought to most often utilize hospital emergency departments and federally qualified health centers/clinics.

The last portion of the survey asked key informants to identify challenges in the community in maintaining healthy lifestyles and to make recommendations or suggestions for improving health and quality of life. In addition to issues related to access to care, informants listed motivation/effort, education/knowledge, cultural norms, and environment/safety as challenges in the community. To address these issues, informants recommended increasing awareness, education, community outreach, and community collaboration and coordination. They also suggested that more programs for youth and seniors be offered and that the community space be enhanced.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS & PLANNING

Prioritization Session

On June 17, 2013, approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for the development of the hospital's Implementation Strategy. A list of attendees can be found in Appendix G.

Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans. Master list of community priorities (Presented in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

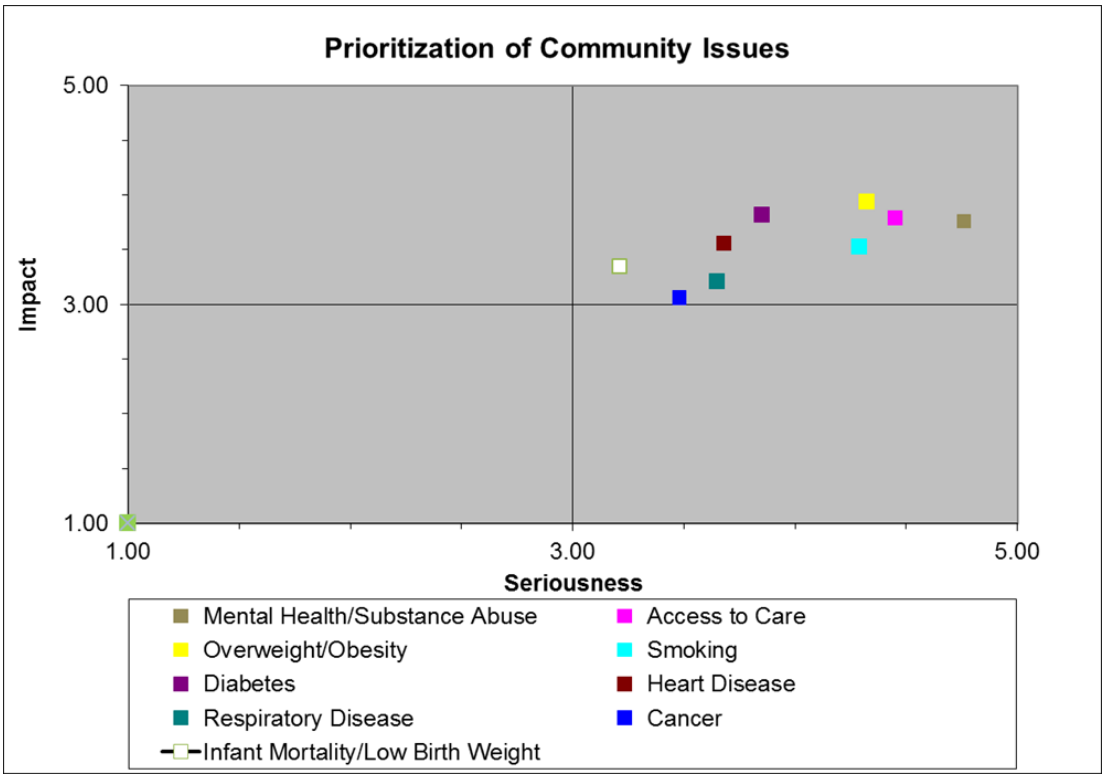
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

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

Goal Setting

Following the prioritization session, The Greater Waterbury Health Improvement Partnership representatives met to review the identified priorities and develop goal statements to guide community-wide health improvement efforts. The following goals were adopted for each priority area:

Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Overweight and Obesity

Goal: Promote health and reduce chronic disease through healthful eating and physical activity.

Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Action Planning

To set a course for ongoing community health improvement activities and evaluation, a Community Health Improvement Plan (CHIP) was developed by the Greater Waterbury Health Partnership. Additionally, in line with requirements set forth in the ACA, specific Implementation Strategies, outlining how each hospital would work to address the identified needs, were created.

The CHIP and Hospital Implementation Strategies were adopted in September 2013. These documents, as well as a report of the CHNA are available on the partner websites.

APPENDIX A: Secondary Data Profile References

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APPENDIX B: Household Telephone Study Statistical Considerations

The Household Telephone Study sampling strategy was designed to represent Waterbury and its surrounding towns. The sampling strategy identified the number of completed surveys needed within each ZIP code based on the population statistics from the U.S. Census Bureau in order to accurately represent the area. Call lists of household land-line telephone numbers were created based on the sampling strategy. The final sample (1,121) yields an overall error rate of +/-2.9% at a 95% confidence level. This means that if one were to survey all residents of Waterbury, the final results of that analysis would be within +/-2.9% of what is displayed in the current data set.

Data collected from the 1,121 respondents was aggregated and analyzed by Holleran using IBM SPSS Statistics. The detailed survey report includes the frequency of responses for each survey question. In addition, BRFSS results for Connecticut and the United States are included when available to indicate how the health status of Waterbury residents compares on a state and national level. All comparisons represent 2011 BRFSS data unless otherwise noted. It is important to note a few questions on the survey did not have comparisons to Connecticut and/or national data because of survey modifications.

It is common practice in survey research to statistically weight data sets to adjust for demographic imbalances. For example, in the current household survey, the number of females interviewed is above the actual proportion of females in the area. The data was statistically weighted to correct for this over-representation of females. It should be noted that the national dataset (from the CDC) is also statistically weighted to account for similar imbalances.

APPENDIX C: Household Telephone Study Participant Demographics

Gender and Age

Demographic Category		Waterbury CT 2013 BRFSS (n = 743)	Surrounding Towns 2013 BRFSS (n = 378)
Gender	Male	36.7%	35.4%
	Female	63.3%	64.6%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 735)**	**Surrounding Towns 2013 BRFSS (n = 374)**
Age Group	18 - 24	2.9%	4.8%
	25 - 34	9.0%	5.3%
	35 - 44	10.2%	12.8%
	45 - 54	17.0%	22.7%
	55 - 64	24.4%	21.7%
	65 years and over	36.6%	32.6%

Race and Ethnicity

Demographic Category		Waterbury CT 2013 BRFSS (n = 737)	Surrounding Towns 2013 BRFSS (n = 378)
Hispanic/Latino	Yes	13.0%	2.6%
	No	87.0%	97.4%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 715)**	**Surrounding Towns 2013 BRFSS (n = 377)**
Race	White	73.6%	94.4%
	Black or African American	16.5%	0.8%
	Asian	1.8%	1.6%
	Native Hawaiian or Other Pacific Islander	0.4%	0.0%
	American Indian or Alaska Native	1.4%	0.5%
	Other	6.3%	2.7%

Marital Status and Children

Demographic Category		Waterbury CT 2013 BRFSS (n = 734)	Surrounding Towns 2013 BRFSS (n = 376)
Marital Status	Married	36.2%	58.0%
	Divorced	16.9%	13.0%
	Widowed	17.8%	13.8%
	Separated	3.0%	0.8%
	Never Married	22.9%	12.5%
	Member of an unmarried household	3.1%	1.9%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 742)**	**Surrounding Towns 2013 BRFSS (n = 378)**
Number of Children in Household	None	74.5%	70.9%
	One	12.3%	14.3%
	Two	8.1%	12.2%
	Three	3.2%	2.4%
	Four	1.1%	0.0%
	Five	0.7%	0.3%
	Six	0.1%	0.0%

Educational Attainment

Demographic Category		Waterbury CT 2013 BRFSS (n = 739)	Surrounding Towns 2013 BRFSS (n = 376)
Education Level	Never attended school or only attended kindergarten	0.4%	0.5%
	Grades 1 through 8	3.7%	2.1%
	Grades 9 through 11	6.5%	2.1%
	Grade 12 or GED	31.9%	20.7%
	College 1 year to 3 years	31.8%	27.1%
	College 4 years or more	25.7%	47.3%

Employment Status

Demographic Category		Waterbury CT 2013 BRFSS (n = 741)	Surrounding Towns 2013 BRFSS (n = 376)
Employment Status	Employed for wages,	38.9%	49.2%
	Self-employed,	3.6%	10.1%
	Out of work for more than 1 year,	4.3%	2.7%
	Out of work for less than 1 year,	2.8%	1.6%
	Homemaker,	3.5%	3.2%
	Student,	1.3%	1.9%
	Retired, or	34.5%	26.9%
	Unable to work	10.9%	4.5%

Income

Demographic Category		Waterbury CT 2013 BRFSS (n = 574)	Surrounding Towns 2013 BRFSS (n = 301)
Income	Under $10,000	8.4%	2.0%
	$10,000 to less than $15,000	13.2%	5.3%
	$15,000 to less than $20,000	6.6%	2.3%
	$20,000 to less than $25,000	10.8%	4.3%
	$25,000 to less than 35,000	14.5%	8.3%
	$35,000 to less than 50,000	14.1%	12.6%
	$50,000 to less than 75,000	14.6%	17.9%
	$75,000 or more	17.8%	47.2%

APPENDIX D: Key Informant Participants

Name	Title	Organization
Tina Agati	Executive Director	Literacy Volunteers of Greater Waterbury
Eric Albert	President	Albert Brothers, Inc.
Michele A. Albini	Constituent Service Aide	City of Waterbury
Janine Altamirano	Program Coordinator	Waterbury Department of Public Health
Maryangela Amendola	Director	Chase Family Resource Center
Joel Becker	President & Chief Executive Officer	Torrco
Carolann Belforti	JobLinks Coordinator	Northwest Regional Workforce Investment Board
Michelle Bettigole	Executive Director	The Watermark at East Hill
Christine Bianchi, MSW, LCSW	Chief Developmental Officer	Staywell Health Care, Inc.
O. Joseph Bizzozero, MD	Administration	Alliance Medical Group
Charles Boulier	President & Chief Executive Officer	Naugatuck Savings Bank
Samuel Bowens	HIV Prevention Coordinator	Waterbury Health Department
Betty Bozzuto	Chief Nursing Officer	Saint Mary's Hospital
Ellen Brotherton	Assistant Director	Western CT Mental Health Network - Waterbury
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Katherine Carten	Parish Administrator	Saint Michael's Parish, Naugatuck
Ellen Carter	Program Officer	Connecticut Community Foundation
Kathy Case	Director of Program Management	Waterbury ARC
Julie Clark	Wellness Environmental Lifestyle Consultant	
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Meghan Cleary	Director of Nursing	Wolcott View Manor
Mary Conklin	Housing Attorney	Connecticut Legal Services
Joseph G. Conrad	Program Director	Connecticut Counseling Centers, Inc.
Ronald Conti	Vice President	Heritage Village
Marilyn Cormack	President	BHCare
JoAnne Cosgriff, MD	Director, Performance Improvement	Waterbury Hospital
Janice Crelan	Assistant Treasurer	Hubbard-Hall, Inc.
Kelly Cronin	Executive Director	Waterbury Youth Services
Andrea Cuff, APRN		Chase Outpatient
Jerome Dais	Elder	Family Worship Center
Kristen Davila	Director	Morris Senior Center
Nancy Deming	Director	VNA Northwest
Catherine R. Dinsmore	Senior Center Director	Falls Avenue Senior Center
Deborah Duarte	Missions President	Community Tabernacle Outreach Center
Richard Dumont	Community Resident	
Kris Durante	Coordinator	Bridge To Success
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Tim Epperson	Food Pantry Coordinator	Greater Waterbury Interfaith Ministries
Michelle Fica	Managing Attorney	Connecticut Legal Services
Bethany Ann Fickes	Office Assistant	Saint Mary's Hospital
Christina Fishbein	Executive Director	Western Connecticut Area Agency on Aging
Ron Flormann	Chief Commercial Officer	Glenwood Systems, LLC
Natalie Forbes	Grant Coordinator	Waterbury Hospital
Auguste Fortin, VI, MD	Physician	Yale Primary Care Residency Program/ Waterbury Hospital
Yvette Highsmith Francis	Regional Director	Community Health Center, Inc.
Todd Gaertner	Nursing Home Administrator	Lutheran Home of Southbury

Sarah Geary	Constituent Services Manager	City of Waterbury
Sharon Gesek	Director of Elderly Services	Town of Southbury
Bill Gibbs	Owner	Bill Gibbs Massage Therapy
Mary-Kate Gill	Director of Elder Services	New Opportunities, Inc.
Jackie Giordano, RN	Nurse	Saint Mary's Hospital
Michelle Godin	Director	Saint Mary's Hospital
Joe Gorman	Supervisor of Health & Physical Education	Waterbury Board of Education
Lydia Granitto	Membership & Marketing Manager	Girl Scouts of Connecticut
Bernadette Graziosa	President	The Grotto Restaurant & Mrs. G's Gift Baskets
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Joy Hall	Director	Salvation Army
Lori Hart	Director	Bridge To Success
Robyn Hawley	Director of Behavioral Health	Catholic Charities Archdiocese of Hartford
Eileen Healy	Executive Director	Independence Northwest, Inc.
Tina Herman	Assistant Director of Critical Care	Waterbury Hospital
Arlene G. Herrick	Property Manager	Grace Meadows Elderly Housing
Chris Hibbs	Health & Wellness Director	Greater Waterbury YMCA
Stephen Holt	Assistant Professor	Yale Primary Care Residency
Geralyn Hoyt	Chief	Southbury Ambulance
Lucia Hughes	Manager	Waterbury Hospital
Stephen Huot, MD	Director	Yale Primary Care Residency Program/ Waterbury Hospital
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Eric Hyson, MD	Attending Physician	Waterbury Hospital
Sandi Iadarola	Chief Nursing Officer	Waterbury Hospital
Azhar Imam, MD	Chief of Psychiatry	Saint Mary's Hospital
Kristen Jacoby, MPH	President/Chief Professional Officer	United Way of Greater Waterbury
Donna Johnson	Community Relations Liaison	Diagnostic Radiology Associates
Mark Johnson, LMFT	Program Director	Wellspring Foundation
Jan Kennedy	Executive Director	Cardiology Associates of Greater Waterbury, LLC
Elizabeth Korn, APRN	Nurse	Saint Mary's Hospital
Lisa Labonte	SNS Director	New Opportunities, Inc.
Leo Lavallee	Principal	Waterbury Arts Magnet School
Stephen Lewis	Chief Executive Officer/President	Thomaston Savings Bank
The Rev. Jeanne Lloyd	Minister	Mattatuck Unitarian Universalist Society
Ben Loveland	Assistant Director	Waterbury Hospital
Vanessa Lucewicz	Practice Manager	Franklin Medical Group
Frederick Luedke	Chairman, Board of Greater Waterbury Health Network Inc.	Waterbury Hospital
Neal Lustig	Director of Health	Pomperaug Health District
Robin Marino	Clinical Manager	Saint Mary's Hospital
Judith Martin	Program Coordinator	Child & Adolescent Behavioral Health
Kate Mattias	Executive Director	National Alliance on Mental Illness Connecticut
Bahar Matusik	Clinical Pharmacy Manager	Waterbury Hospital
Jennifer McGarry	Patient Services Manager	Leukemia and Lymphoma Society
Patricia A. McKinley	Strategic Volunteer to Non-Profit Organizations	Waterbury Health Home Coalition; United Way Greater Waterbury; Connecticut Community Foundation
Kathleen McManamy, LCSW	Regional Supervisor	Connecticut Community Care, Inc.
Kathleen McNamara	Community Resident	
Emmett McSweeney	Library Director	Silas Bronson Library
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Chris Miller	Administrative Fellow	Saint Mary's Hospital

Thomas Missett	Chief Development Officer	Waterbury Hospital
Alan C. Mogridge	Executive Director	Valley YMCA
Peg Molina	Director of Social Services	Town of New Milford
Patrick Morgan	Interim Director Surgical Services	Waterbury Hospital
Drew Morten	Physician Assistant	Connecticut Academy of Physician Assistants
Luci Moschella	Nursing Supervisor	Waterbury Health Department
Lois Mulhern	Nursing Supervisor	Waterbury Health Department
Melanie Nachajska, LCSW		YNA Health Care
James O'Rourke	CEO	Waterbury YMCA
Peggy Panagrossi	Executive Director	Safe Haven of Greater Waterbury
Kim Pernerewski	President	National Alliance on Mental Illness Waterbury
Peter Porrello, MD	Physician	Waterbury Hospital
Pamela Pratt	Manager, OP Behavioral Health	Saint Mary's Hospital
Fenn Quigley	Community Resident	
Ernst Racine, Jr.	Family Center Coordinator/Fatherhood Specialist	Catholic Charities
Loryn Ray, MPH	Director of Elderly Services	Town of Woodbury
Pamela Redmond	Public Affairs Officer	VA Connecticut Healthcare System
Thomas E. Reinahrdt, MD	Chief of Psychiatry	Waterbury Hospital
Laurie Reisman	Director of Operations	Family Services of Greater Waterbury, Inc.
JoAnn Reynolds-Balanda	VP Community Impact	Untied Way of Greater Waterbury
Diane Rokosky, R.N		Public Health Deptartment
P. Russell	Community Resident	
William Rybczyk	Director Research, Development, & Planning	New Opportunities, Inc
Linda Sapio-Longo, APRN	Family Nurse Practitioner	Waterbury Hospital Infectious Disease Clinic
John A. Sarlo	Director	Mattatuck Senior Center, Inc.
Donita Semple	Senior Manager, Performance Improvement	Waterbury Hospital
Loraine Shea	Director	Waterbury Hospital
Frank Sherer	Senior Vice President	Timex Group
Carl Sherter, MD	Chief of Staff	Waterbury Hospital
Catherine Sousa	Supervisor of Patient Transport	Saint Mary's Hospital
Linda Spadaccini	Library Director	Waterbury Hospital
Susan Stauffacher	Chairman	Roxbury Council on Aging
Gary Steck	Chief Executive Officer	Wellmore Behavioral Health
Monica Stokes	Assistant Manager Customer Support	Waterbury Hospital
Christine Thomas-Melly	Benefits Manager	Waterbury Hospital
Donald Thompson	Chief Executive Officer	Staywell Health Center
Joseph M. Tuggle, MD	Physician	Complete Newborn Care, PC
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Kara Vendetti	WIC Program Coordinator	Waterbury Health Department-WIC Program
Deborah Vitarelli	Executive Director	Waterbury Arc, Inc.
Kathy Volz	Practice Manager CFHC	Franklin Medical Group at Saint Mary's Hospital
Chad Wable	President & Chief Executive Officer	Saint Mary's Hospital
Julie Weidemier	Assistant Director	Waterbury Hospital
Claude E. Williams	Executive Director	Mount Olive A.M.E. Zion Senior Citizens Center, Inc.
Jeffrey Williams	Grant Writer	Waterbury Hospital
Eileen Woods	Assistant Director Telemetry	Waterbury Hospital
Kathy Woods	Executive Director	Living in Safe Alternatives, Inc.
D. Woolley	VP Human Resources	Waterbury Hospital
Randy York	Infant Immunization Coordinator	Waterbury Health Department
Mary Zasada	Clinical Informatics Manager	Saint Mary's Hospital
Melissa Zwang	Program Director	New Opportunities, Inc.
Patricia Zuccarelli	Director	Department of Children & Families

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT Q22-2

CHNA IMPLEMENTATION PLAN

Waterbury Hospital

CHNA IMPLEMENTATION STRATEGY

BACKGROUND

Waterbury Hospital was the first hospital in the city of Waterbury and has served the area since 1890. In its first year, Waterbury Hospital served 85 patients and had a staff of 21. It is now licensed for 357 beds and employs more than 2,000 people. The hospital serves approximately 15,000 inpatients, 160,000 outpatients, and 58,000 emergency department visits annually. The mission of Waterbury Hospital is to provide compassionate high quality health care services through a family of professionals and services. The vision of Waterbury Hospital is to be the health care organization of choice by providing superior customer service to patients and physicians.

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

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Waterbury Hospital's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs. Waterbury Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA.

THE CHNA PROCESS

A comprehensive CHNA was conducted and included a variety of quantitative and qualitative research components. These components included the following:

1. Secondary Data Profile
2. Statistical Household Survey
3. Focus Groups
4. Key Informant Interviews
5. Prioritization of Identified Community Needs

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Connecticut Department of Public Health, and Centers for Disease Control and Prevention. The information profiles the most recent year health indicators, census figures, household statistics, morbidity and mortality rates, and socioeconomic measures for the city.

A **Statistical Household Survey** was completed with 1,100 community residents. The survey aligns with the Behavioral Risk Factor Surveillance System) study promoted by the Centers for Disease Control and Prevention (CDC). The survey assessed indicators such as general health status, prevention activities (screenings, etc.), and risky behaviors (alcohol use, etc.). The results were examined by a variety of demographic indicators including age and gender. Special attention was given to identifying the needs of underserved individuals, including low-income, minority, and chronic condition populations in the county.

Holleran conducted six **Focus Groups** to better understand health issues related to access to care, health education/communication, healthy behaviors, and community health infrastructure. A total of 24 health care providers and 33 community residents participated in the six focus groups. Holleran analyzed the results of the findings to determine commonalities between populations and uncover themes to aid Waterbury Hospital in addressing the identified barriers.

Key Informant Interviews were collected via an online survey administered by Holleran. A total of 205 community leaders, including public health experts, health and human services providers, and representatives of underserved populations participated in the survey. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived quality of care, key health issues prominent in the community, and quality of life issues.

A **Prioritization Session** was held on June 18, 2013. Approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 CHNA and prioritize key health needs. Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. Please see Appendix A for a listing of individuals who attended the session.

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

In June 2013, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the CHNA data. The planning meeting was initiated and facilitated by the Greater Waterbury Health Improvement Partnership. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives for the day were outlined as follows:

- To review recently compiled community health data and highlight key research findings;
- To initiate discussions around additional key health issues not represented in the CHNA;
- To prioritize the community health needs based on select criteria

Prioritization Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.
Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans.

Master list of community priorities (Presented in alphabetical order.):

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

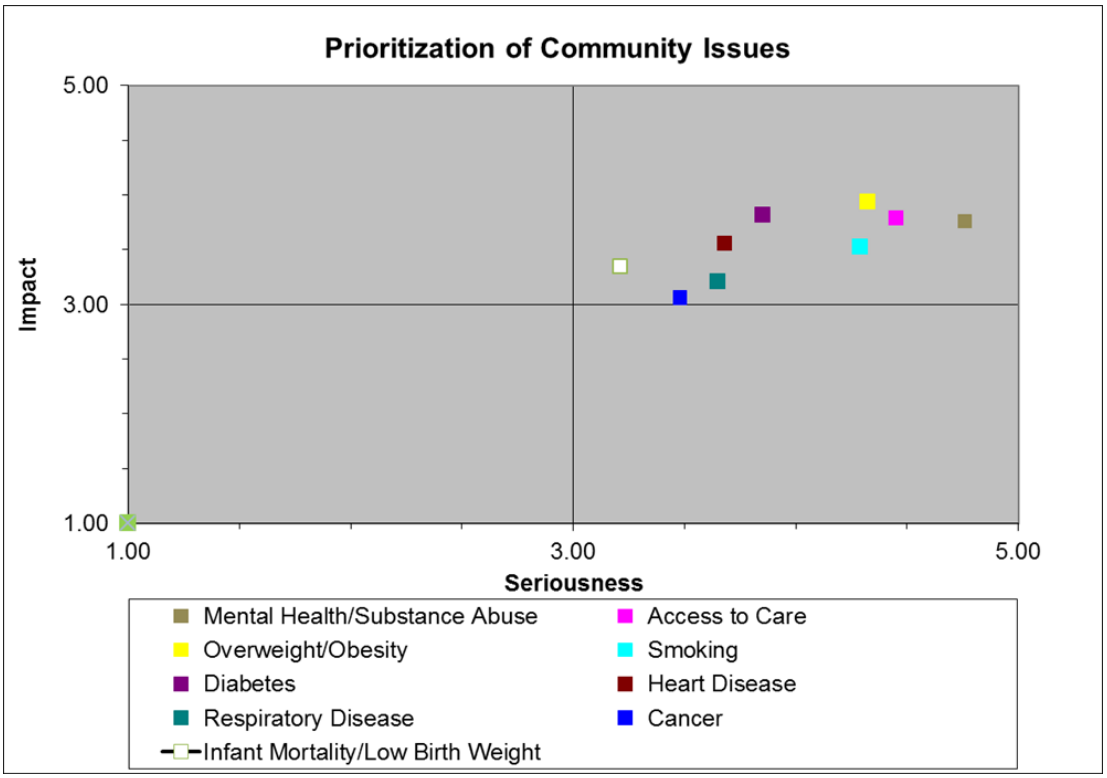
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following five priority areas for Waterbury were adopted:

A. Access to Care
B. Mental Health/Substance Abuse
C. Overweight/Obesity
D. Smoking

WATERBURY HOSPITAL'S STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Waterbury Hospital's Implementation Strategy illustrates the hospital's specific programs and resources that will support ongoing efforts to address the identified community health priorities. This work will be supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, related objectives and strategies, and inventory of existing community assets and resources for each of the four priority areas are listed below.

A. ACCESS TO CARE

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of persons with health insurance
- Increase the proportion of persons who have a specific source of ongoing care
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
- Increase the number of health providers that accept Medicaid and Medicare

Strategies:

1. Increase the number of patients screened and enrolled in insurance programs by WHAP case managers by 10% at the 6 sites in the City of Waterbury by utilizing Certified Assisters to access the CT Health Exchange in response to the Affordable Care Act.

2. Increase the number of patients enrolled in Project Access by 10% for donated, primary and specialty care, reduced prescriptions and Medicare copay assistance, and donated lab and radiology hospital-based services.

3. Provide technical assistance to WHAP sites at St. Mary's Hospital and StayWell Health Center to enable them to track recidivism in the ED for non-emergency codes.

4. Offer 2 onsite bi-lingual medical Spanish classes for 15 clinical staff per class to improve communication with patients.

5. Introduce the CultureVision database to enable healthcare professionals and facilities to provide culturally competent patient care.

Existing Resources:

Underserved Populations
Waterbury Hospital works closely with local healthcare providers and community-based organizations to identify healthcare needs for underserved patients throughout the Waterbury community. Through these collaborations, Waterbury Hospital works to develop key programming for the city's vulnerable populations such as: the Waterbury Hospital Infectious Disease Clinic, which provides comprehensive HIV care to ~500 People Living with HIV/AIDS; and The Waterbury Health Access Program, which provides comprehensive case management services to over 3,000 uninsured and underinsured patients annually; and the Waterbury Hospital Chase Diabetes Disease Management Clinic, is one of the many free clinics offered at Chase Outpatient Center; others include Rheumatology, Surgery, Gastroenterology, Dermatology, Podiatry, and Psychiatry.

During 2012, Waterbury Hospital's spectrum of services continued to have a positive impact on the welfare of Waterbury's citizens. To remain consistent with Waterbury Hospital's mission, many of our services are targeted for vulnerable members of our community, including those who are uninsured or underinsured. In order to provide access to continuing high quality professional health care in the Greater Waterbury area, Waterbury Hospital is a site for 40 clinical programs for new health professionals including: Primary Care Residents, Surgical Residents, Nurses, Physician Assistants, Pharmacy Residents, and Radiology Techs. In addition the Waterbury Hospital Youth Pipeline Initiatives target the emerging workforce in area elementary, middle and high schools.

Health Professions Education

Yale Primary Care Internal Medicine Residency Program
During 2012, our Yale Primary Care Internal Medicine Resident activities included:

- Participation in research days at Yale and Waterbury/St. Mary's Hospitals;
- ACP regional and national meetings;
- The annual Health Fair held at the Waterbury YMCA;
- Home/office visits for clinic patients; and
- Educational seminars held at Waterbury Hospital and Yale University.

At Waterbury Hospital, we seek to train physicians who desire a generalist background to their careers in medicine. This program is unique in that it provides the medical residents the opportunity to work each year in a tertiary medical center at Yale-New Haven Hospital, a community hospital at Waterbury Hospital, and outpatient practice sites that include private practice offices and community health centers is unique in residency training. Our graduates are

highly sought after by private practice offices, hospitalist programs, and fellowship programs throughout the country.

Student Nurse Intern Program (SNI)
The SNI program is available for nursing students entering their senior year. The program provides these student nurses with shadowing opportunities so they can apply their content knowledge to authentic patient care situations. Staff RNs serve as the students' mentors as the students accompany them on their medical rounds. The goals of the program are: (1) to provide the student nurses with the knowledge and skills necessary to pass the NCLEX exam and (2) to socialize the student nurse in an attempt to decrease the stress of assimilating into the hospital's work environment, should they be hired as Graduate Nurses at Waterbury Hospital.

Physician's Assistant (PA) Students
P.A. students from Quinnipiac University completed clinical rounds in several departments around the hospital, including the Operating Room, Emergency Department, Behavioral Health, and Radiology. The experience is designed for the student to learn to apply the knowledge gained from didactic course work in medicine, surgery, and the basic and behavioral sciences into the clinical arena resulting in the ability to successfully manage patients in a thorough and comprehensive manner. The primary goal of clinical rotations is to expose the student to patients of all ages, patients in a variety of different settings, and patients with a broad range of medical, surgical, and psychosocial problems.

The P.A. students participate in:

- History taking;
- Examining the patient;
- Assisting in and/or performing diagnostic testing;
- Assisting in and/or performing therapeutic tasks;
- Oral presentations;
- Medical documentation of the patient encounter;
- Formulating a differential diagnosis and problem list;
- Formulating a treatment plan; and
- Counseling of patients regarding medication, diet, and lifestyle changes such as smoking cessation, exercise, and well-being.

Radiology Students from NVCC
The Naugatuck Valley Community College (NVCC) Radiology students are involved with many activities while assigned to Waterbury Hospital. Under the supervision of a NVCC clinical instructor and hospital radiologic technologists, the students are assigned to the various radiographic suites and modalities. During their assignment, students are performing or assisting with radiographic procedures, including chest x-rays, skeletal exams, fluoroscopic procedures, mobile x-rays in the various patient units, and surgical cases. The students also increase the number of individuals available in the department to assist in moving and transporting patients as well as chaperoning sensitive exams. In addition to the diagnostic

radiology the students are assigned to experiences in Interventional Radiology, CT, MRI, Nuclear Medicine, and Ultrasound. Students work in these modalities under the direct supervision of the hospital staff.

Waterbury Hospital's affiliation with NVCC as a clinical site for students has many benefits. Perhaps the single most important benefit is the hospital has a continuous stream of potential radiology employees. Students are in the program for 22 months and in that time become very familiar with the hospital equipment, routines, personal, and mission. This provides Waterbury Hospital with new employees who have a strong skill set and proven dedication to the hospital community.

Waterbury Hospital Youth Pipeline Initiatives

The Waterbury Hospital Youth Pipeline Initiatives were established in 2001 as a partnership between Waterbury Hospital and Waterbury Public Schools. The mission of the program is: "to close the achievement gap for minority and economically disadvantaged students in Waterbury so they can matriculate and compete nationally for placement in post-secondary education programs in preparation for health careers". Waterbury Hospital is committed to enhancing and enriching the academic opportunities and personal journeys of our youth, who are the emerging workforce of tomorrow. To this end, during 2012, Waterbury Hospital continued to provide 383 students and parents in Greater Waterbury with unique educational programs that will enhance the overall welfare of our community. The WH Youth Pipeline Initiatives had four focus areas during FY 2012, including:

Providing Early Acquaintance with Careers in Healthcare (PEACH)

Since its inception in 2004, Waterbury Hospital's Providing Early Acquaintance with Careers in Healthcare (PEACH) Program has engaged administrators, teachers, and students at Waterbury's North End Middle School and West Side Middle School to address projected shortages of healthcare workers and to close the achievement gap for students in Waterbury Public Schools. Through the PEACH Program, students engage with healthcare workers in a non-emergency setting and are informed of the variety of healthcare career opportunities available in our community. Each spring, approximately 100 seventh graders from Waterbury take part in a day-long PEACH tour at Waterbury Hospital, during which they visit at least six hospital departments and complete hands-on learning activities with hospital staff. Annually, Waterbury Hospital also offers its PEACH Spring Break Exploration Camp, this year 38 middle school students from Waterbury took part in: shadowing and hands-on learning activities at the hospital; CPR certification; and educational sessions at Bridgeport's Discovery Museum.

Parent Leadership Training Institute (PLTI)

In 2012, twenty four individuals from Greater Waterbury successfully completed Waterbury's PLTI, a 20-week curriculum teaching leadership and advocacy skills. Waterbury Hospital has hosted the Waterbury PLTI since 2000, and the program has trained and graduated over 175 area parents. PLTI's core mission is to impart leadership and advocacy skills to parents while simultaneously educating them about volunteerism, civic life, and the process by which state

and local governments enact and change laws. Each participant completes and implements a community project; examples of projects from 2012 include: a "High School Driving Education" program (a City-wide initiative to introduce safe driving techniques in high schools) and "The C.H.I.P. Forum" (Children Having Involved Parents—a series of workshops to underline the importance of giving encouragement and support to our children so they can succeed in life).

Parents Supporting Educational Excellence (PSEE)
In 2012, twenty-one individuals from Greater Waterbury successfully completed Waterbury's PSEE, a 13-week curriculum co-created by the Connecticut Center for School Change and the Connecticut Commission on Children for parents (defined broadly as parents, guardians, family members and grandparents) to instill leadership skills in education and to facilitate partnerships between school staff and parents to improve student learning.

WH Summer Bridge Program
During the summer of 2012, twenty-eight students from Waterbury, grades 6-11, participated in the WH Summer Bridge Program. 100% of meals were secured for the program from City of Waterbury Summer Food Program and 8 local restaurants/businesses. Students completed the following modules:

- 78.5 hours of Academic preparation
- 15 hours of job shadowing sessions (Radiology, Nuclear Medicine, Nursing, MRI, Case Management, Dr. S. Aronin (ID Inpatient Rounding), ICU Medical Rounds, Health Information Management, Access Rehab, Behavioral Health, Respiratory Therapy, Finance, WH ID Clinic, Security, Orthopedics, Pharmacy, Infection Control and Surgery.
- 14 hours of Photography instruction
- 4 hours of computer sessions
- 2 full-day field trips completed: one to Yale University for an admissions info session and campus tour and one to Hammonasset State Park including three educational sessions at Meigs Point Nature Center
- 3 hours of healthcare career searches
- 3 hours of college admissions presentations completed by UCONN Waterbury & Yale ROTC
- 1 hour of individual academic advising
- 2 hours of team building activities
- 2 hours of health topics presentations completed, including HIV 101 and Healthcare Jeopardy.

Waterbury Health Access Program
Waterbury Hospital is aware of the economic needs many patients in our community, and, as a result, we remain committed to the Waterbury Health Access Program. Founded in 2003 as a partnership between Waterbury Hospital, St. Mary's Hospital, StayWell Health Center (FQHC), and the Waterbury Health Department, the Waterbury Health Access Program improves access to high-quality medical care by providing comprehensive case management, pharmacy

assistance, and access to primary and sub-specialty medical care for the uninsured and underinsured residents of the Greater Waterbury region. During FY 2012, the Waterbury Health Access Program had over 4,700 active clients. Additionally, Waterbury Hospital provided $784,879 worth of donated services to WHAP's patients.

Waterbury Hospital Infectious Disease Clinic (WHIC)
The WHIC offers a comprehensive "one-stop shopping" model that provides patients with on-site primary and specialty services, medical case management, individualized medication adherence services, mental health and substance abuse services, nutrition counseling, individualized HIV education, laboratory testing, and radiology services. WHIC's providers include three board-certified/board-eligible Infectious Disease specialists as well as an Advanced Practitioner Nurse and a Registered Dietician, all with expertise in the management of patients with HIV/AIDS. In FY 2012, WHIC served around 500 People Living with HIV/AIDS (PLWHA).

WHIC's staff members actively participate in statewide and area collaboratives, such as the Connecticut HIV Planning Consortium (CHPC) and the Ryan White Part A Planning Council, and WHIC facilitates the Greater Waterbury HIV Consortium. WHIC has a very active Consumer Advisory Group (CAG), which organizes social and testing events for the community and facilitates the Waterbury Hospital Photography Group.

The WHIC also has a Hepatitis C clinic, run by an Advanced Practitioner Nurse. From October 2004 to Present, nearly 200 Hepatitis C mono- and co-infected (Hepatitis C and HIV) patients have been evaluated at the ID Clinic. The Hepatitis C clinic provides a consultation with a nutritionist to advise on healthy eating; coordination with mental health services; and educational sessions on side effect management, the importance of hydration and adherence, and positive coping strategies.

Be Well Bus
In order to ensure that patients have access to medical appointments, at the hospital and at local physicians' offices, Waterbury Hospital's Be Well Bus provides transportation services to patients from Waterbury and eleven of its surrounding towns. During FY 2012, the Be Well Bus completed over 4,170 transports to and from medical appointments. Waterbury Hospital has contracted with a transportation provide to offer the bus service, and area providers pay a small fee to participate.

Diabetes Disease Management (DDM) Clinic
The DDM utilizes a multidisciplinary case management approach to develop treatment plans and monitor patient progress. The DDM Clinic provides >150 diabetics with self-management skills and clinical care. The clinical team meets weekly on Wednesdays to develop treatment plans for new patients and collaborate on the progress of existing patients.

Evergreen 50 Club
Waterbury Hospital's Evergreen 50 Club is an organization comprised of over 15,000 members over the age of 50. The Club offers wellness programming, Medicare counseling, and health education presentations on a variety of topics are presented by health care professionals. Presentation topics include: holistic health, varicose vein treatment, heart disease, summer skin care, weight loss, blood pressure, bladder screenings, joint care and replacement, nutrition, and resolving adverse outcomes with patients and families. Annually, the Evergreen 50 Club hosts a health fair for its members, which provides free flu shots and healthcare screenings.

Family Birthing Center
Providing a child-centered focus, Waterbury Hospital's Family Birthing Center offers expectant parents a variety of classes to prepare them for their baby's arrival. Between breast feeding, childbirth, infant care classes, and nutritional presentations at our Family Birthing Center provided vital instruction to over 120 persons last year.

Heart Center of Greater Waterbury
Formed in collaboration with Saint Mary's Hospital, the Heart Center of Greater Waterbury provides diverse medical support initiatives to help educate residents in the Greater Waterbury community about pertinent health and wellness issues. This past year, the Heart Center conducted a series of health fairs and various health and wellness education sessions, including "Ask the Nurse," which provides patients with complimentary blood pressure screenings and health awareness education and a "Freedom from Smoking" series to help our residents kick the habit. During FY 2012, the Heart Center's programs served over 3,280 residents from the Greater Waterbury Area.

Thank God I'm Female
For the past 20 years, Waterbury Hospital's "Thank God I'm Female" has served as an annual women's wellness forum that features 40 educational booths and health-related giveaways. The ultimate goal of the forum is to educate attendees about stress, mental well-being, heart health, diet, healthy cooking, osteoporosis and bone health, change of life, and more. In 2012, over 400 area residents attended the event.

Waterbury Research Day
Through collaboration with St. Mary's Hospital in Waterbury, CT, Waterbury Hospital hosted its annual Waterbury Research Day. During the day, resident physicians, pharmacy residents, and medical students present research projects to the physician community. High school students are also encouraged to participate in the activities.

B. MENTAL HEALTH AND SUBSTANCE ABUSE

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase the proportion of adults with mental health disorders and/or substance abuse who receive treatment
- Increase mental health and substance abuse screening by primary care providers
- Increase cultural competency among mental health and substance abuse providers
- Increase number of points of access for referral to services
- Reduce stigma of mental health and substance abuse disorders
- Increase community support structures and individual resiliency skills
- Increase the proportion of adolescents never using substances
- Reduce illegal substance use

Strategies:

1. Establish bi-annual education/family support seminars which would be available to clients, families and community members.

2. Expand student/intern program to provide clinical training rotations throughout the Department of Behavioral Health. Up to 5 academic year internships would be offered annually to master's level students pursuing education in addictions and mental health.

3. Initiate specialized programming on the inpatient adolescent unit to incorporate Dialectical Behavior Therapy (DBT) skills as well as goal setting to decrease the rates of seclusion and restraint.

4. Maximize resources within the Access Center to increase number of individuals served by 10% by providing assistance and "bridge" treatment to ensure continuity of care between services, and urgent/emergent assistance where needed to prevent decompensation and unnecessary hospitalization.

Existing Resources:

Behavioral Health

Waterbury Hospital's Behavioral Health Department is one of the region's largest service providers offering a full continuum of care for children, adolescents and adults. Our services also outreach to the community through regular participation in health fairs, elected membership in the Northwest Regional Mental Health Board, as a host site to numerous twelve-step meetings and the provision of case management as well as acute services to the homeless within the City of Waterbury.

Grandview Adult Behavioral Health
Grandview Adult Behavioral Health is the adult component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals ages eighteen and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; gender specific programming, cognitive therapy and DBT (Dialectical Behavior Therapy). Services provided in the Intensive Outpatient and traditional Outpatient Programs include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy

West Main Behavioral Health
West Main Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age eighteen and up who suffer from a variety of substance use disorders as well as concurrent psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders. Specialty services include the use of evidence based interventions in particular; motivational interviewing, cognitive therapies and suboxone induction/maintenance.

Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, ambulatory detoxification, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, family therapy and multifamily therapy are also provided when clinically indicated. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Center for Geropsychiatry
The Center for Geropsychiatry is one of the adult components of the Behavioral Health Department ambulatory care service. Comprehensive psychiatric treatment is offered to individuals age sixty and up who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.

Services provided in the Outpatient Program include comprehensive psycho diagnostic assessment and evaluation, family therapy, group therapy, milieu therapy, and pharmacotherapy. Individual and Family Therapy is provided as needed.

Child and Adolescent Behavioral Health
Child and Adolescent Behavioral Health is a component of the Behavioral Health Department ambulatory care services. Comprehensive psychiatric treatment is offered to individuals' age ten to eighteen who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, anxiety disorders, and adjustment disorders.

Limited outpatient services are provided to individuals aged 12-21 who are transitioning to outpatient and/or adult services. Intensive ambulatory services are organized to promote recovery from psychiatric disorders through active treatment outside of an inpatient setting. Services provided in the Partial Hospital include comprehensive psycho diagnostic assessment and evaluation, group therapy, milieu therapy, and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are also provided when clinically indicated. Transportation services are available to patients for partial hospital visits as needed. The Partial Hospital Program provides a minimum of four hours of direct clinical service per day.

Services provided in the Intensive Outpatient Program and Outpatient Service include comprehensive psycho diagnostic assessment and evaluation; group therapy; milieu therapy; and pharmacotherapy. Individual therapy, marital, family therapy and multifamily therapy are provided when clinically indicated.

Crisis Center/ Access Center

The Crisis Center provides urgent/emergent evaluations and short term treatment to all individuals presenting to the Emergency Department and/or Crisis offices with immediate and acute behavioral health needs. Consultation services are provides on the inpatient medical floors when ordered by an attending physician. Evaluative services are provided for any individual regardless of their age.

Services are provided to individuals who suffer from a variety of psychiatric or emotional disorders including, but not limited to, affective disorders, psychotic disorders, substance use disorders, cognitive/dementia, anxiety disorders, and adjustment disorders.
Active collaboration and coordination of care occur with the patients, the crisis clinicians and community provides to ensure a smooth transition from crisis services to the next appropriate treatment setting.

Program hours are Seven days per week between 8 am and midnight. Services are open and available 365 days per year.

Center for Behavioral Health

Behavioral Health Services provided include psychiatric evaluations, OT/AT evaluations, family therapy, group therapy, didactic educational groups, individual counseling and recreational services all within a milieu framework offering twenty four hours services within an inpatient hospital setting. Inpatient services are available within separate subunits to adolescents (ages 12- 18) as well as adults age 18 and over. Diagnostic services are available when indicated within the general hospital and include clinical laboratory, radiology and medical/service allowing for comprehensive consultations.

Our efforts are aimed at promoting the benefits of clinical treatment as well as positive lifestyle choices. Every effort is made to educate clients, their families and the community about mental

illness and the impact treatment can have on one's illness. The ultimate goal is to help people feel better, reduce or resolve symptoms and to minimize the stigma of mental illness.

Support Groups
During 2012, Waterbury Hospital hosted several support groups for its patients and their families, including:

- Behavioral Health's parent and sibling support group, which offers emotional assistance to families who have children in treatment; and
- Alcoholics Anonymous, serves over 4,000 people annually, meets weekly throughout the year, and is coordinated by our Behavioral Health Department.

C. OVERWEIGHT AND OBESITY

Goal: Promote health and reduce chronic disease through healthy(ful) eating and physical activity

Objectives:

- Reduce percent of overweight and obese residents
- Increase access and consumption of healthy foods
- Increase food security by addressing/reducing hunger
- Increase access to and use of safe areas for physical activity
- Increase residents knowledge/awareness of a balanced diet and physical activity
- Reduce risk factors for chronic disease

Strategies:

1. The WH Wellness Committee initiates events and activities focused at supporting the physical and mental wellbeing of the WH staff and residents in the county. Initiatives include: (1) Establish a weekly Farmer's Market in conjunction with Waterbury's Brass City Harvest on Hospital grounds to increase access to and encourage consumption of healthful foods. (2) Establish a "Get Moving" program to encourage physical fitness for employees, patients, and community members.

2. Increase nutritional education within the child and adolescent Behavioral Health program as well as the implementation of a "low ropes" program to increase self-awareness, skill building, and physical fitness.

3. Increase the number of patients receiving nutritional counseling and self-management education at WH ID Clinic, and WH DDM Clinic by 10%. Referrals to the WH outpatient dietitian are made when clinically indicated.
4. Publish calorie counts for all foods in the WH Cafeteria by December 2014.

5. Conduct an employee health risk assessment in January 2015 to 100% of WH employees with health insurance through WH to encourage positive health engagement with a discount deductible incentive.

6. Expand the physical fitness program in collaboration with the Waterbury YMCA at the DDM Clinic to include 20 patients of the WH ID Clinic.

Existing Resources:

Nutritional Counseling
Patients admitted to WH (inpatient) are screened within 24 hours to assess for nutrition risk; those patients that are at high nutrition risk trigger a consult to the Registered Dietitian. MDs and other providers can order an RD consult for any patient they feel should be seen by an RD (including diet education). In addition, all patients of WH DDM Clinic and WH ID Clinic are seen by a Registered Dietitian and are provided with appropriate nutritional counseling and self-management training. Patients at both clinics are seen as often as necessary to teach nutrition concepts and help them to make desired lifestyle changes; these patients are seen at least annually.

Supporting Community Need
The WH ID Clinic runs a Food Pantry for HIV patients. WH also routinely responds to requests from the community through organized campaigns for specific items run by its employees ie the annual Thanksgiving Turkey drive in November and the annual Cereal drive in May, to help families prepare to feed children breakfast during the summer months when school is out.

Patient Fitness
The DDM Clinic has established an established an arrangement with the Greater Waterbury YMCA to provide monthly memberships to DDM patients to promote a regular exercise regime; 21 patients were referred from January through November 2012.

Employee Fitness
WH maintains an onsite Fitness Center for employee use, open 24 hours a day, seven days a week. Employees pay a one-time, $10 life-time membership fee. WH employees also receive a discount on Waterbury YMCA memberships. Additionally, WH supports on-line participation in Weight Watchers programs for its employees.

Community Fitness
The Evergreen 50 Club offers multiple 'keep fit' programs for community members and staff over 50 years old. Classes include Pilates and weight training.

D. TOBACCO USE

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

- Reduce smoking and overall tobacco use among adults, adolescents and children
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation attempts and recent successes by smokers
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase tobacco free environments

Strategies:

1. Provide tobacco screening to 100% of patients and education to 100% of patients who smoke before their discharge from WH.
2. Increase tobacco screening and education to 100% of outpatients seen in the primary care medical practice for continuity visits at the Chase Outpatient Center. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
3. Screen 100% of patients in the WH ID Clinic for tobacco use. Provide smoking cessation education and information about the CT Quitline (1-800-QUIT-NOW) to 100% of tobacco users.
4. Participate in the American Lung Foundation's annual 'Great American Smoke Out' program through the WH Wellness Committee.

Existing Resources:

WH successfully transitioned to a Tobacco free campus in November 2010.

Tobacco screening is provided to 100% of patients in the WH Behavioral Health Department and education is provided to 100% of patients who tobacco users. Resource information on smoking cessation is provided in all patient waiting areas.

WH is collaborating with the Regional Mental Health Board and will be providing smoking cessation groups along with one to one telephonic coaching.

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Waterbury Hospital plans to address all four of the prioritized community health needs identified through the 2013 Community Health Needs Assessment and prioritized by community representatives.

APPROVAL FROM GOVERNING BODY

The Waterbury Hospital Board of Directors met on September 26, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the **2013 Waterbury CHNA Final Report**, the **2013 CHNA WH Implementation Plan**, and the **2013 CHNA WH Implementation Plan Summary**, and provide the necessary resources and support to carry out the initiatives therein.

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

EXHIBIT Q25-1

CURRICULUM VITAE/BIOGRAPHICAL PROFILES: GWHN

DARLENE STROMSTAD, FACHE
President and Chief Executive Officer

Darlene Stromstad assumed leadership of Waterbury Hospital in July 2011 after serving as President and CEO of Goodall Hospital in Sanford, Maine, for six years. Prior to that, she was Senior Vice President at Catholic Medical Center in Manchester, N.H., and Vice President at St. Joseph's Healthcare in Nashua, N.H. Last year, she was elected to the national Board of Governors of the American College of Healthcare Executives, and is a past board member of the Maine Hospital Association, the York County United Way, and has chaired the American Heart Association's Red Dress Campaign for York County. She is a native of North Dakota who received her BA from the University of North Dakota, Grand Forks, and her MBA from Rivier College in Nashua, N.H.

Michael Cemeno, VP and CIO

Mike joined us in 2012 and is a nationally recognized CIO who has led Waterbury Hospital to 3 consecutive Most Wired Awards. He is responsible for IT, Telecom, Clinical Engineering and Facilities. Over the last 3 years his team was responsible for implementation of CPOE, Nursing Documentation, and now Physician Documentation moving the hospital from HIMSS Level 4 to HIMSS Level 6. We also achieved MU II certification in the same time frame. Barcode Med Administration and Medical Device Integration are just two areas of IT that were implemented for enhanced patient safety.

Mike was the Associate CIO for Yale New Haven Health System for the previous 8 years and CIO of a 4 hospital system (Greater Hudson Valley Health System) in Mid-State New York for 5 years prior to that. Mike has a BBA from Temple University.

David J. Pizzuto, M.D. - Vice President of Medical Affairs/CMO

Dr. Pizzuto became the Vice President of Medical Affairs/CMO in June 2011. A graduate of The Waterbury Hospital Internal Medicine Residency Program (1987), he has been a member of the Attending Medical Staff since January 1988. In addition to his administrative duties, Dr. Pizzuto also continues to practice Internal Medicine full time. Additionally, Dr. Pizzuto has held various leadership roles at Waterbury Hospital including Chairman Department of Medicine (1997-2007), Chief of Staff (2008-2010), and member of the Board of Trustees (2011 – present).

Dr. Pizzuto holds an M.D. from New York Medical College (1984), a Master of Science from the University of Minnesota (1980), and a Bachelor of Science from the University of Connecticut (1977). He is certified by the American Board of Internal Medicine (1996 and 2006 –recertified).

MARK HOLTZ, MS, FACHE

Mark Holtz is Currently Senior Vice President and Chief Operating Officer of the Greater Waterbury Health Network in Waterbury Connecticut. In this role, Mark's current responsibilities are for Patient Care Services, Contracted Services, Hospital Outpatient Services, Laboratory, Pharmacy, Alliance Medical group, and the Cardiology Service line including the Cardiology Associates of Greater Waterbury. Mark's prior positions include, SVP/COO of Glens Falls Hospital in NY, COO of Overlook Medical Center which is part of the Atlantic Health System, and SVP of Operations for Lehigh Valley Health Network. Mark received his Bachelor of Arts in Psychology from Herbert H. Lehman College of the City University of New York in 1979, and Master of Science in Healthcare Systems Management from Iona College in New Rochelle NY in 1984. Mark is also a Fellow of the American College of Healthcare Executives.

James Moylan
Interim Chief Financial Officer

Jim has spent his entire 43year professional career in healthcare finance in CT. Currently he is self- employed as a consultant and interim executive manager. In 2012 he retired from Griffin Hospital as its CFO for 12 years and prior to that was the CFO of Bristol Hospital for 14 years. He received his bachelor's degree from Bentley University, and his masters from Rensselaer-Hartford.

John Camus

Current:
Vice President Physician Practices
Alliance Medical Group / Waterbury Hospital

Previous Experience:
Vice President Operations
Delphi Of TeamHealth
Vice President Physician Services
Mountainside Hackensack UMC
Director Physician Practice
Newport Hospital
Chief Executive Officer
Olean Medical Group
Vice President Operations
Hampden County Physician Associates
Vice President Operations
RiverBend Medical Group

Education:
Western New England University - MBA
University of Massachusetts - BA Japanese Language
Assumption College - BA Sociology

Sandra A. Iadarola, RN, MBA, CPHQ
Chief Nursing Officer/Vice President of Patient Care Services

Sandra had worked in this role since early 2011. She has operational accountability for 38 departments, including all inpatient and several outpatient services. These include Behavioral Health, Critical Care services, Family Care services and Surgical services. She oversees all Nursing functions within the organization. She has also serves as Chairperson of the Board of Directors for our affiliate, the VNA Health at Home. From 2002 to 2011, Sandra was the Administrative Director of Med/Surg and Critical Care Services at Waterbury Hospital. She served as the implementation project lead for the initiation of the open heart surgery program and as the clinical transformation lead for the electronic medical treatment record implementation. Prior to 2002, Sandra was the Vice President for Patient Care Services at Charlotte Hungerford Hospital in Torrington, CT.

Dr. Richard P Kropp, Ed.D. SPHR, SHRM-SCP
Principal Consultant

Dr. Kropp is Vice President for Human Resources for Waterbury Hospital and has been a principal consultant at The Kropp Group, a full-service management consultancy servicing an international client base. He has also been also affiliated with NRS Global Partners which is a search and technology consulting firm. Dr. Kropp is a human resource and organizational development executive with extensive success in the comprehensive leadership of large human resource organizations.

He has proven success in the conceptualization, implementation and administration of corporate universities. Dr. Kropp has demonstrated expertise in business, analytical, and negotiation skills. In addition, he is a motivational team leader with a track record of effectively leading and managing organizations of one to more than a hundred members. He has also published several books on such subjects as team building, team leadership, and business communication

He has also served as the Chief Human Resource Officer for Cape Cod Healthcare, Steward Healthcare, and Lourdes Health System.

Dr. Kropp has consulted and trained for companies in the health care, finance, high tech and educational fields on the design and implementation of human resource management systems. He has progressive experience in line and staff management, project management, organization development and sales telemarketing education. Dr. Kropp spent ten years in various training and organizational development positions at Wang Labs, where he created and implemented programs to select, develop, and appraise the top 300 managers, developed Executive Compensation and Succession Management Systems, and developed corporate-wide selection processes.

He has also held training management positions at the First National Bank of Boston and The Bell Telephone Company of Pennsylvania. In addition, he developed and facilitated open enrollment and on-site programs in project management, management development and continuous improvement for Boston University Corporate Education Center. Dr. Kropp has also served as a Program Manager/Facilitator for a service excellence standards program implemented by General Motors at hundreds of automotive dealerships in the United States.

Education:

He earned his doctoral in Industrial and Humanistic Psychology from Boston University. He holds a Bachelor's degree from the Mansfield University of Pennsylvania and a Masters in Human Resources from The Pennsylvania State University.

Publications

"Team Workout," HRD Press, 2008.
"Human Resource Planning & Development in Healthcare" in "Best Practices in Human Resource Management," Jossey-Bass, 2006.
"Self-Directed Teams," HRD Press, 2001.
"New Teams," HRD Press, 2000.
"50 Activities for Team Building," HRD Press, 1999.
"Performance Management and Collaborative Leadership," AMS Press, 1998.
"Communicating in the Business Environment," HRD Press, 1993.

Presentations:

Work-Life Balance; a presentation at the 2015 CIO conference at Boston; March 2015

The Current State of the Healthcare Industry and its Impact on Human Resource Management; a presentation to the CHE/Trinity Healthcare Human Resource Community. Philadelphia; June 2014

360 Evaluations and the Principle of Followership; a presentation to the CHE/Trinity Healthcare Human Resource Community. Philadelphia; April 2013

Critical Thinking for Human Resource Professionals; a workshop for the JPMorgan Human Resource Community. Wilmington, Del. August 2013

Employment Law and the Supervisor; NRS Global Partners Associates Meeting, August 2012. Boston, MA

Leadership in the Ever Changing Healthcare World; Lourdes Health System Annual Leadership Meeting, Keynote Address; June 11, 2011, Camden, NJ.

Human Resource Issues in Higher Education: A Guided Conversation with the Search Committee for the System Chief Human Resource Officer for The University System of New Hampshire; June 2011

Setting the Standards for On-line Learning; ITI Conference January 2009. Boston, MA

Creating a Corporate University, The 2008 Talent Management Conference, Orlando, March 2008.

Defined Contribution Plans in the Healthcare Setting; a speech to the Lincoln Financial client conference at Philadelphia; November, 2005

Closing the RN gap through Community College and Healthcare System Collaboration, DOL National Conference on Innovations for the Incumbent Workforce, Philadelphia, June, 2005.

Developing the Healthcare Workforce, National Workforce Investment Board Conference, Washington, DC, February, 2005.

Human Resource Planning in Healthcare; A speech to the Health Information Conference of VA, September, 2002.

The Leader Manager in Healthcare, Linkage OD Conference, Naples, FL and Chicago, IL, 2000.

Patricia Gentil, MS, RHIA, CHC

Patricia Gentil is the Compliance and Privacy Officer at Waterbury Hospital. Patricia is responsible for the compliance program and compliance reporting systems. She is also responsible for the specific policies and procedures related to corporate compliance and HIPAA privacy. In addition she is responsible for the compliance committee and manages regulatory compliance audits, as well as conducts compliance and Privacy investigations. Patricia also oversees the HIM and Case Management Departments. She plays a key role in revenue cycle management and most recently has led the ICD-10 implementation efforts at Waterbury Hospital. Patricia is certified in Healthcare Compliance through the CCB and is also certified as an RHIA through AHIMA.

EXHIBIT Q25-2

PMH BIOGRAPHICAL PROFILES

RESPONSE TO QUESTION #25
BIOGRAPHICAL SUMMARIES

Sam Lee is Chairman of the Board of Directors and Chief Executive Officer ("CEO") of Prospect Medical Holdings, Inc. ("PMH"). Mr. Lee was appointed as PMH's CEO on March 19, 2008 and as Chairman of PMH's board of directors on May 14, 2008. Mr. Lee was previously appointed as a member of PMH's board of directors and as CEO of Alta Hospitals System, LLC ("Alta Hospitals"), the current corporate hospital segment and a subsidiary of PMH, on August 8, 2007. In 1998, Mr. Lee co-founded Alta Hospitals (formerly Alta Healthcare System, Inc.) with David Topper (see below) after acquiring seven (7) Los Angeles area hospitals from Paracelsus Healthcare Corporation ("Paracelsus"). Previously, he served as the President of Alta Hospitals from January 2002 until PMH acquired Alta Hospitals. Mr. Lee's background involves healthcare and technology related private equity investment management, operational leadership, entrepreneurship, mergers and acquisitions, and leveraged financing for various corporations. Prior to joining Alta Hospitals, Mr. Lee was a General Partner with Kline Hawkes & Co., a $500 million private equity firm located in Brentwood, California, that focuses on healthcare, technology, and business services.

David Topper is President of Alta Hospitals, a position he has served since 2007. He previously served as Alta Hospitals' CEO and a member of its Board of Directors between 1998 and 2007. In 1998, Mr. Topper co-founded Alta Hospitals with Mr. Lee. Prior to his involvement with Alta Hospitals, Mr. Topper served as Senior Vice President of Development and Hospital Operations for Paracelsus. Additionally, Mr. Topper has held healthcare executive management positions as a Hospital Administrator with Ramada Medical Corporation and as a Regional Vice President with Community Psychiatric Centers.

Dr. Mitchell Lew is President of PMH. Previously, Dr. Lew served as CEO of PMS since May 2012 and as the designated physician shareholder since February 1, 2013. He served as the Chief Medical Officer for PMS from December 2008 through December 2012. Prior to joining PMS, Dr. Lew was the CEO of Genesis HealthCare of Southern California, Inc. ("Genesis") from 1999 to 2006. In November 2005, Genesis was acquired by a company affiliated with PMS. From 1991 to 2001, Dr. Lew was the President of Lew Medical Group Inc., a medical group in which he also maintained a medical practice specializing in General Obstetrics and Gynecology.

Stephen O'Dell is Senior Vice President, Coordinated Regional Care for PMH. In this role, Mr. O'Dell leads the Company in its efforts to integrate~~d~~ our regional delivery systems among physicians, hospitals and payors. He is responsible for the development, implementation and oversight of the Company's coordinated regional care delivery systems in each of its regional markets. Prior to joining PMH, Mr. O'Dell served as Senior Vice President, Growth and Corporate Development, at Molina Healthcare. Before that, Mr. O'Dell held managed care senior executive positions with Blue Cross Blue Shield, United Healthcare, FHP International and First Consulting Group.

Steven Aleman is Chief Financial Officer of PMH, a position he has held since 2013. Prior to that appointment, Mr. Aleman, who is a certified public accountant, served as PMH's Vice President, Finance and Development since August 2010. Between May 2009 and July 2010, Mr. Aleman served as the CFO of SCH at Culver City, formerly known as Brotman Medical Center, Inc., a hospital subsidiary of PMH. From July 2008 through April 2009, Mr. Aleman held the position of Vice President of Internal Audit at PMH. Between 1998 and 2008, Mr. Aleman served in several positions ending as the Staff Vice President of Compliance with Wellpoint, Inc.

Ellen Shin, Esq. is General Counsel and Secretary of PMH, a position she has held since 2008. Ms. Shin is responsible for overseeing the legal and regulatory affairs of PMH and its affiliates, including corporate governance, regulatory compliance, litigation, transactions, government affairs and public policy activities. Prior to serving in her current position, Ms. Shin was the General Counsel and Secretary of Alta Hospitals from June 2006 to March 2008, where she oversaw the sale of Alta Hospitals to PMH. Prior to joining Alta, Ms. Shin was in private practice at several national and regional law firms in Los Angeles, California.

Cindra Syverson is Senior Vice President, Chief Human Resources Officer. Previously, Ms. Syverson spent seven years with Seattle-based Providence Health System as the corporate SVP, Chief Human Resources Officer. She also was the principle consultant of Syverson Consulting, Inc., which supported organizations talent and success management strategies, human resource operations improvement, culture change management and employee engagement and labor relations strategies. She has also held senior executive human resources positions with St. Joseph Health System, and PacifcCare/FHP.

Von Crockett is Senior Vice President, Corporate Development of PMH. Prior to that appointment, Mr. Crockett served as the Chief Executive Officer of SCH at Culver City from 2009 to 2012. Prior to joining SCH at Culver City, Mr. Crockett was the President and Chief Executive Officer, beginning in 2007, of Centinela Hospital Medical Center, a hospital with 369 licensed beds, 500 affiliated physicians, 1,500 staff and $260 Million annual net revenue, located in Los Angeles, California. From 2004 into 2007, Mr. Crockett served as the System Chief Operating Officer of Centinela Freeman Health System in Los Angeles, California. Between 2002 and 2004, he served first as the Chief Operating Officer and then the Chief Executive Officer for Doctors Medical Center San-Pablo/Pinole in San Pablo, California. He also served as the Chief Financial Officer of Sutter Healthcare, in Antioch, California, and Sharp Healthcare Corporation, in San Diego, California, from 2000 through 2002 and 1991-1999, respectively. Prior to those positions, he served in several finance related positions within the industry.

Hoyt Sze is Vice President, Chief Compliance Officer and Privacy Officer for PMH. Mr. Sze oversees and manages the compliance and privacy programs for the Company and its affiliates. Previously, Mr. Sze was a partner at McDermott Will & Emery LLP, a deputy

federal public defender at the Office of the Federal Public Defender and an associate at Latham & Watkins.

EXHIBIT Q37-1

FINANCIAL WORKSHEET (C) FOR THE HOSPITAL ONLY, AND FOR GWHN AND PMH WITHOUT THE CON PROJECT (columns 1,2,5,8 &11), WITH THE CON PROJECT AND INCREMENTAL TO THE CON PROJECT (remainder columns)

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Greater Waterbury Health Network

Financial Worksheet (C):

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

		(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 15 Projected	FY 16 Projected	FY 16 Projected	FY 16 Projected	FY 17 Projected	FY 17 Projected	FY 17 Projected	FY 18 Projected	FY 18 Projected	FY 18 Projected
	Description	W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**										
1	Total Gross Patient Revenue	$1,000,485,065	$1,006,038,550	$12,320,599	$1,018,359,149	$1,019,877,764	$37,398,352	$1,057,276,117	$1,029,226,891	$50,446,545	$1,079,673,437
2	Less: Allowances	$743,265,348	$745,519,202	$9,153,034	$754,672,236	$756,087,352	$27,783,423	$783,870,775	$763,176,134	$37,476,990	$800,653,124
3	Less: Charity Care	$5,144,570	$5,228,272	$63,353	$5,291,625	$5,228,272	$192,305	$5,420,577	$5,228,272	$259,400	$5,487,672
4	Less: Other Deductions	$9,054,147	$12,436,400	$111,498	$12,547,898	$12,436,400	$338,446	$12,774,846	$12,436,400	$456,529	$12,892,929
	Net Patient Service Revenue	**$243,021,000**	**$242,854,677**	**$2,992,713**	**$245,847,389**	**$246,125,740**	**$9,084,179**	**$255,209,919**	**$248,386,086**	**$12,253,626**	**$260,639,712**
5	Medicare	$94,049,325	$93,959,132	$1,119,364	$95,078,496	$94,250,524	$3,397,755	$97,648,279	$94,408,975	$4,583,224	$98,992,198
6	Medicaid	$49,412,291	$53,348,771	$635,560	$53,984,332	$53,529,715	$1,929,201	$55,458,916	$53,615,899	$2,602,295	$56,218,194
7	CHAMPUS & TriCare	$361,306	$371,375	$4,424	$375,799	$372,204	$13,430	$385,634	$372,816	$18,115	$390,931
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$143,822,921**	**$147,679,278**	**$1,759,349**	**$149,438,627**	**$148,152,443**	**$5,340,386**	**$153,492,829**	**$148,397,690**	**$7,203,633**	**$155,601,323**
9	Commercial Insurers	$100,411,947	$101,432,721	$1,208,399	$102,641,120	$104,211,277	$3,668,015	$107,879,292	$106,209,755	$4,947,777	$111,157,532
10	Uninsured	$128,767	$182,978	$2,180	$185,158	$183,574	$6,617	$190,191	$183,574	$8,925	$192,499
11	Self Pay	$784,862	$800,705	$9,539	$810,244	$805,705	$28,955	$834,660	$808,060	$39,058	$847,118
12	Workers Compensation	$1,419,020	$1,111,804	$13,245	$1,125,049	$1,123,658	$40,205	$1,163,863	$1,134,847	$54,233	$1,189,080
13	Other	($3,546,517)	($8,352,810)	$0	($8,352,810)	($8,350,917)	$0	($8,350,917)	($8,347,840)	$0	($8,347,840)
	Total Non-Government	**$99,198,078**	**$95,175,399**	**$1,233,364**	**$96,408,762**	**$97,973,297**	**$3,743,793**	**$101,717,090**	**$99,988,396**	**$5,049,993**	**$105,038,389**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$243,021,000**	**$242,854,677**	**$2,992,713**	**$245,847,389**	**$246,125,740**	**$9,084,179**	**$255,209,919**	**$248,386,086**	**$12,253,626**	**$260,639,712**
14	Less: Provision for Bad Debts	$4,347,405	$3,468,763	$42,746	**$3,511,509**	$3,516,689	$129,796	**$3,646,485**	$3,543,303	$174,802	**$3,718,105**
	Net Patient Service Revenue less provision for bad debts	**$238,673,596**	**$239,385,914**	**$2,949,967**	**$242,335,881**	**$242,609,051**	**$8,954,382**	**$251,563,434**	**$244,842,783**	**$12,078,824**	**$256,921,607**
15	Other Operating Revenue	$11,694,375	$14,643,067	$0	**$14,643,067**	$14,825,462	$0	**$14,825,462**	$14,878,373	$0	**$14,878,373**
17	Net Assets Released from Restrictions	$5,080,455	$5,251,632	($2,625,816)	**$2,625,816**	$5,251,632	($5,251,632)	**$0**	$5,251,632	($5,251,632)	**$0**
	TOTAL OPERATING REVENUE	**$255,448,426**	**$259,280,613**	**$324,151**	**$259,604,764**	**$262,686,146**	**$3,702,750**	**$266,388,896**	**$264,972,788**	**$6,827,192**	**$271,799,980**
B.	**OPERATING EXPENSES**										
1	Salaries and Wages	$120,430,846	$115,590,029	$889,836	$116,479,865	$117,692,915	$2,701,039	$120,393,954	$119,507,521	$3,643,425	$123,150,946
2	Fringe Benefits	$35,027,007	$33,907,301	$261,026	$34,168,326	$34,900,546	$800,964	$35,701,510	$36,161,608	$1,102,459	$37,264,067
3	Physicians Fees	$14,968,038	$12,697,776	$0	$12,697,776	$12,680,260	$0	$12,680,260	$12,682,807	$0	$12,682,807
4	Supplies and Drugs	$29,295,392	$23,712,061	($890,238)	$22,821,823	$23,917,529	($1,406,932)	$22,510,597	$24,142,219	($1,024,865)	$23,117,354
5	Depreciation and Amortization	$7,063,006	$6,849,701	$285,714	$7,135,415	$6,838,400	$857,143	$7,695,543	$6,830,365	$1,428,571	$8,258,936
6	Provision for Bad Debts-Other[b]	$15,000	$15,000	$0	$15,000	$15,000	$0	$15,000	$15,000	$0	$15,000
7	Interest Expense	$1,172,296	$1,346,266	($625,122)	$721,144	$1,346,016	($1,277,229)	$68,787	$1,346,016	($1,309,637)	$36,379
8	Malpractice Insurance Cost	$8,268,731	$6,901,688	$0	$6,901,688	$6,928,910	$0	$6,928,910	$6,931,831	$0	$6,931,831
9	Lease Expense	$4,045,091	$3,612,010	$0	$3,612,010	$3,623,435	$0	$3,623,435	$3,635,055	$0	$3,635,055
10	Other Operating Expenses	$53,166,763	$57,710,072	($1,345,271)	$56,364,801	$57,496,322	($2,012,615)	$55,483,707	$57,779,059	($1,319,221)	$56,459,838
	TOTAL OPERATING EXPENSES	**$273,452,169**	**$262,341,904**	**($1,424,055)**	**$260,917,849**	**$265,439,334**	**($337,630)**	**$265,101,703**	**$269,031,481**	**$2,520,732**	**$271,552,212**
	Provision for Income Taxes[c]	$141,985	$136,181	$785,217	**$921,398**	$136,181	$2,172,366	**$2,308,546**	$136,181	$2,050,340	**$2,186,521**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**($9,768,441)**	**$5,134,676**	**$1,408,798**	**$6,543,474**	**$5,431,229**	**$3,620,294**	**$9,051,523**	**$4,117,688**	**$4,425,395**	**$8,543,083**
	INCOME / (LOSS) FROM OPERATIONS	**($18,145,727)**	**($3,197,472)**	**$962,989**	**($2,234,483)**	**($2,889,369)**	**$1,868,015**	**($1,021,354)**	**($4,194,874)**	**$2,256,121**	**($1,938,753)**
	NON-OPERATING INCOME / REVENUE	$2,425,698	$3,442,234	$0	**$3,442,234**	$3,467,981	$0	**$3,467,981**	$3,494,886	$0	**$3,494,886**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Greater Waterbury Health Network

Financial Worksheet (C):

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

			(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:		FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
			Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description		W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES		**($15,720,030)**	**$244,762**	**$962,989**	**$1,207,751**	**$578,612**	**$1,868,015**	**$2,446,627**	**($699,988)**	**$2,256,121**	**$1,556,133**
C.	**Retained Earnings / Net Assets, beginning of year**		**$45,505,137**	**$29,061,392**	**$0**	**$29,061,392**	**$29,306,154**	**$0**	**$29,306,154**	**$29,884,766**	**$0**	**$29,884,766**
	Retained Earnings / Net Assets, end of year		**$29,061,392**	**$29,306,154**	**$962,989**	**$30,269,143**	**$29,884,766**	**$1,868,015**	**$31,752,781**	**$29,184,779**	**$2,256,121**	**$31,440,900**
	Principal Payments		$44,701	$29,709	($29,709)	**$0**	$14,001	($14,001)	**$0**	$6,571	($6,571)	**$0**
D.	**PROFITABILITY SUMMARY**											
1	Hospital Operating Margin		**-7.0%**	**-1.2%**	**297.1%**	**-0.8%**	**-1.1%**	**50.4%**	**-0.4%**	**-1.6%**	**33.0%**	**-0.7%**
2	Hospital Non Operating Margin		**0.9%**	**1.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**1.3%**
3	Hospital Total Margin		**-6.1%**	**0.1%**	**297.1%**	**0.5%**	**0.2%**	**50.4%**	**0.9%**	**-0.3%**	**33.0%**	**0.6%**
E.	**FTEs**		**1,417**	**1,484**	11	**1,495**	**1,486**	35	**1,521**	**1,489**	47	**1,536**
F.	**VOLUME STATISTICS**[d]											
1	Inpatient Discharges		11,699	11,344	113	**11,457**	11,344	340	**11,684**	11,344	908	**12,252**
2	Outpatient Visits		188,806	192,582	2,042	**194,624**	192,582	6,466	**199,048**	192,582	9,075	**201,657**
	TOTAL VOLUME		**200,505**	**203,926**	**2,155**	**206,081**	**203,926**	**6,806**	**210,732**	**203,926**	**9,983**	**213,909**

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

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

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

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

Assumed no increases in volume. Only increase was managed care

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Waterbury Hospital

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

Financial Worksheet (C):

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14 Actual	FY 15 Projected	FY 15 Projected	FY 15 Projected	FY 16 Projected	FY 16 Projected	FY 16 Projected	FY 17 Projected	FY 17 Projected	FY 17 Projected	FY 18 Projected	FY 18 Projected	FY 18 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$905,475,426	915,214,960		$915,214,960	$921,598,035		$921,598,035	$934,060,739		$934,060,739	$942,681,350		$942,681,350
2	Less: Allowances	$679,028,148	698,950,496		$698,950,496	$702,469,850		$702,469,850	$712,240,611		$712,240,611	$718,999,172		$718,999,172
3	Less: Charity Care	$5,839,904	5,156,745		$5,156,745	$5,243,272		$5,243,272	$5,243,272		$5,243,272	$5,243,272		$5,243,272
4	Less: Other Deductions	$8,287,736	9,039,311		$9,039,311	$12,421,400		$12,421,400	$12,421,400		$12,421,400	$12,421,400		$12,421,400
	Net Patient Service Revenue	**$212,319,638**	**$202,068,409**	**$0**	**$202,068,409**	**$201,463,513**	**$0**	**$201,463,513**	**$204,155,456**	**$0**	**$204,155,456**	**$206,017,506**	**$0**	**$206,017,506**
5	Medicare	$88,141,859	$77,846,951		$77,846,951	$77,683,507		$77,683,507	$77,683,507		$77,683,507	$77,683,507		$77,683,507
6	Medicaid	$31,612,939	$41,641,364		$41,641,364	$45,383,059		$45,383,059	$45,383,059		$45,383,059	$45,383,059		$45,383,059
7	CHAMPUS & TriCare	$278,693	$257,504		$257,504	$264,002		$264,002	$264,002		$264,002	$264,002		$264,002
8	Other				$0			$0			$0			$0
	Total Government	**$120,033,491**	**$119,745,818**	**$0**	**$119,745,818**	**$123,330,568**	**$0**	**$123,330,568**	**$123,330,568**	**$0**	**$123,330,568**	**$123,330,568**	**$0**	**$123,330,568**
9	Commercial Insurers	$94,143,393	$86,925,320		$86,925,320	$87,669,528		$87,669,528	$90,361,471		$90,361,471	$92,223,521		$92,223,521
10	Uninsured		$0		$0			$0			$0			$0
11	Self Pay		$0		$0			$0			$0			$0
12	Workers Compensation		$0		$0			$0			$0			$0
13	Other	($1,857,246)	($4,602,729)		($4,602,729)	($9,536,583)		($9,536,583)	($9,536,583)		($9,536,583)	($9,536,583)		($9,536,583)
	Total Non-Government	**$92,286,147**	**$82,322,591**	**$0**	**$82,322,591**	**$78,132,945**	**$0**	**$78,132,945**	**$80,824,888**	**$0**	**$80,824,888**	**$82,686,938**	**$0**	**$82,686,938**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$212,319,638**	**$202,068,409**	**$0**	**$202,068,409**	**$201,463,513**	**$0**	**$201,463,513**	**$204,155,456**	**$0**	**$204,155,456**	**$206,017,506**	**$0**	**$206,017,506**
14	Less: Provision for Bad Debts	$3,692,986	3,602,119		**$3,602,119**	$2,696,864		**$2,696,864**	$2,732,899		**$2,732,899**	$2,757,825		**$2,757,825**
	Net Patient Service Revenue less provision for bad debts	**$208,626,652**	**$198,466,291**	**$0**	**$198,466,291**	**$198,766,649**	**$0**	**$198,766,649**	**$201,422,556**	**$0**	**$201,422,556**	**$203,259,680**	**$0**	**$203,259,680**
15	Other Operating Revenue	$2,671,751	1,164,098		**$1,164,098**	$2,364,706		**$2,364,706**	$2,364,706		**$2,364,706**	$2,364,706		**$2,364,706**
17	Net Assets Released from Restrictions	$5,542,491	5,080,455		**$5,080,455**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**	$5,251,632		**$5,251,632**
	TOTAL OPERATING REVENUE	**$216,840,894**	**$204,710,844**	**$0**	**$204,710,844**	**$206,382,987**	**$0**	**$206,382,987**	**$209,038,894**	**$0**	**$209,038,894**	**$210,876,018**	**$0**	**$210,876,018**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$83,908,937	$82,721,899		$82,721,899	$77,111,340		$77,111,340	$78,653,567		$78,653,567	$80,226,638		$80,226,638
2	Fringe Benefits	$23,614,272	$28,882,017		$28,882,017	$27,269,762		$27,269,762	$28,417,803		$28,417,803	$29,645,411		$29,645,411
3	Physicians Fees	$17,306,125	$11,926,799		$11,926,799	$11,229,459		$11,229,459	$11,229,459		$11,229,459	$11,229,459		$11,229,459
4	Supplies and Drugs	$29,780,875	$27,722,303		$27,722,303	$21,913,022		$21,913,022	$22,125,763		$22,125,763	$22,344,887		$22,344,887
5	Depreciation and Amortization	$7,077,295	$6,340,513		$6,340,513	$6,200,315		$6,200,315	$6,200,315		$6,200,315	$6,200,315		$6,200,315
6	Provision for Bad Debts-Other[b]	$0	$0		$0	$0		$0			$0			$0
7	Interest Expense	$1,196,363	$1,169,431		$1,169,431	$1,345,947		$1,345,947	$1,345,947		$1,345,947	$1,345,947		$1,345,947
8	Malpractice Insurance Cost	$6,226,587	$6,543,668		$6,543,668	$5,392,785		$5,392,785	$5,392,785		$5,392,785	$5,392,785		$5,392,785
9	Lease Expense	$2,599,451	$2,852,443		$2,852,443	$2,401,696		$2,401,696	$2,401,696		$2,401,696	$2,401,696		$2,401,696
10	Other Operating Expenses	$56,039,173	$57,223,873		$57,223,873	$58,849,639		$58,849,639	$58,393,012		$58,393,012	$58,506,655		$58,506,655
	TOTAL OPERATING EXPENSES	**$227,749,078**	**$225,382,944**	**$0**	**$225,382,944**	**$211,713,965**	**$0**	**$211,713,965**	**$214,160,347**	**$0**	**$214,160,347**	**$217,293,793**	**$0**	**$217,293,793**
	Provision for Income Taxes[c]				**$0**			**$0**			**$0**			**$0**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**($2,634,526)**	**($13,162,156)**	**$0**	**($13,162,156)**	**$2,215,284**	**$0**	**$2,215,284**	**$2,424,809**	**$0**	**$2,424,809**	**$1,128,487**	**$0**	**$1,128,487**
	INCOME / (LOSS) FROM OPERATIONS	**($10,908,184)**	**($20,672,100)**	**$0**	**($20,672,100)**	**($5,330,978)**	**$0**	**($5,330,978)**	**($5,121,453)**	**$0**	**($5,121,453)**	**($6,417,775)**	**$0**	**($6,417,775)**
	NON-OPERATING INCOME / REVENUE	$3,136,173	$2,503,676		**$2,503,676**	$2,658,589		**$2,658,589**	$2,658,589		**$2,658,589**	$2,658,589		**$2,658,589**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**($7,772,011)**	**($18,168,424)**	**$0**	**($18,168,424)**	**($2,672,389)**	**$0**	**($2,672,389)**	**($2,462,864)**	**$0**	**($2,462,864)**	**($3,759,186)**	**$0**	**($3,759,186)**
C	**Retained Earnings / Net Assets, beginning of year**	**$18,667,399**	**$11,890,055**		**$11,890,055**	**($4,698,443)**		**($4,698,443)**	**($7,370,832)**		**($7,370,832)**	**($9,833,696)**		**($9,833,696)**

Assumed no increases in volume. Only increase was managed care

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: Waterbury Hospital

Financial Worksheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 14	FY 15	FY 15	FY 15	FY 16	FY 16	FY 16	FY 17	FY 17	FY 17	FY 18	FY 18	FY 18
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	Retained Earnings / Net Assets, end of year	$11,890,055	($4,698,443)		($4,698,443)	($7,370,832)		($7,370,832)	($9,833,696)		($9,833,696)	($13,592,881)		($13,592,881)
	Principal Payments				$0			$0			$0			$0
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	-5.0%	-10.0%	0.0%	-10.0%	-2.6%	0.0%	-2.6%	-2.4%	0.0%	-2.4%	-3.0%	0.0%	-3.0%
2	Hospital Non Operating Margin	1.4%	1.2%	0.0%	1.2%	1.3%	0.0%	1.3%	1.3%	0.0%	1.3%	1.2%	0.0%	1.2%
3	Hospital Total Margin	-3.5%	-8.8%	0.0%	-8.8%	-1.3%	0.0%	-1.3%	-1.2%	0.0%	-1.2%	-1.8%	0.0%	-1.8%
E.	**FTEs**	1,152	1,028		1,028	1,091		1,091	1,091		1,091	1,091		1,091
F.	**VOLUME STATISTICS**[d]													
1	Inpatient Discharges	11,693	11,699		11,699	11,344		11,344	11,344		11,344	11,344		11,344
2	Outpatient Visits	199,362	188,806		188,806	192,582		192,582	192,582		192,582	192,582		192,582
	TOTAL VOLUME	211,055	200,505	0	200,505	203,926	0	203,926	203,926	0	203,926	203,926	0	203,926

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

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

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

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

EXHIBIT Q38-1

ASSUMPTIONS UTILIZED IN DEVELOPING FINANCIAL WORKSHEET (C)

Assumptions Utilized in Developing Financial Worksheet (C):

Waterbury Hospital:

FY15: October through August actual results annualized.

FY16:

Revenue and Volume – annualized 5 months of actual results (February through June). Included additional revenue for anticipated increase in outpatient visits and known revenue increases from Medicare and Commercial Insurances.

Expenses – annualized 7 months of actual results (October through April). Included any projected increases.

Both revenue and expenses reflect expected changes due to the impact of the recent State Supplemental Pool payment cuts.

FY17 and FY18:

FTEs and Volume was kept the same as the budget. No increases.

Only revenue increase was for known Commercial Insurance revenue increases.

Expenses remained the same as budget with a few increasing by 2-3% each year.

Alliance Medical Group:

For FY15 revenue, we took an average of the previous 11 months for individual government and non-government revenue. For everything else that fiscal year, we used the 11 month year to date plus the month of August 2015 again.

FY 16 is based on potential visit volumes for the upcoming year, with expected changes due to the impact of the recent State Supplemental Pool payments.

FY17 and FY18 is based on the expected increase of 1% and 2% year to year due to the primary care recruitment which will include opening offices in new markets. Expenses stayed the same as FY 16.

For the new fiscal years, there has been extensive evaluation of the expenses associated with the hospital and all affiliates. The hospital engaged the Camden Group to look at opportunities to remove expenses from the organization and we have begun or about to begin implementing many of these based on the data analyzed. Our goal moving forward and starting in FY 2016 is to increase our revenue capability but also make significant changes that will allow us to decrease our expenses where appropriate.

Prospect Incremental Assumptions

FY16 Incremental:

Assumed Conversion date of April 1st, 2016

Revenue and Volume Increases of 1%

Expenses: Loss of 340B Pharmacy Pricing, efficiency on GPO Purchasing Contracts, Volume increases.

Interest Expense related to assumed Capital Leases.

Does not include associated Property and Sales Tax Increases.

FY17 & 18 Incremental:

Revenue and Volume Increases of 3% and 4% respectively.

Expenses: Loss of 340B Pharmacy Pricing, efficiency on GPO Purchasing Contracts, Volume increases.

Interest Expense related to assumed Capital Leases.

Does not include associated Property and Sales Tax Increases.

EXHIBIT Q42-1

STAFFING ATTACHMENT I (2015)

Staffing Attachment I

Question No. 42 - Part a

Current Staffing Levels				Current Staffing Levels			Current Staffing Levels	
Average Nursing staff to patient rato - Item no. i				Average RN to Patient Ratio - Item no. ii			Avg Nursing Hrs/Pt Day - Item no. iii	
Department or Unit Name	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**	**NHpPD**	**Comments**
CVU RN	1:2/3	1:2/3	1:2/3	1:2/3	1:2/3	1:2/3	7	
CVU PCA	1:8	1:8 x 2 hrs	0					
ICU RN	1:2	1:2	1:2	1:2	1:2	1:2	12	
ICU PCA	1:20	1:20	0					
Family Birthing Center (Post Partum-cuplets) RN	1:3-5	n/a 12hour shifts	1:4-5	1:3-5	n/a 12hour shifts	1:4-5		
FBC Surgical Techs	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven		
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven	1 not ratio driven		
Labor and Delivery RN	1:1-2	12 hour shifts	1:1-2	1:1-2	12 hour shifts	1:1-2		nurses work 12 hour shifts
Special Care Nursery RN	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3		
Well Baby Nursery RN	n/a	n/a	1:6	n/a	n/a	1:6		only open on night shift
Telemetry RN	1:4-5	1:4-5	1:5-6	1:4-5	1:4-5	1:5-6	9.0	RN and PCA +MW
Telemetry PCA	1:8-9+Monitor watcher	1:10+MW	1:10+MW					
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7	1:5-6	1:5-6	1:6-7	7.3	RN and PCA
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12					
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7	1:5-6	1:5-6	1:6-7	8.1	Ortho/Neuro unit
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+ PT aid	1:10-12	1:10-12					
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12	1:6-8	1:6-8	1:8-12	7.4	
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12					
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p		Admit RN 11a-11p	Admit RN 11a-11p			
Pomeroy 8 PCA	1*	1*	1*					
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4	1:3-4	1:3-4	1:3-4	6	
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:6-7	1:5-6	1:5-6	1:6-7	7.5	RN and PCA
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12					
Emergency Department RN	C ore: 7/11	11	7/6	C ore: 7/11	11	7/6	n/a	
Emergency Department PCA	Core: 3/4	5	3/2					

FootNote - (1) Nursing staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.
Also included are Surgical and Psychiatric technicians as they provide direct patient care.

EXHIBIT Q42-2

STAFFING ATTACHEMENT II (PROJECTED)

Staffing Attachment I I

Projected Staffing Level FY 2016- Year 1

Question No. 42 - Part b

Projected Staffing Levels			
Average Nurse (1) to Patient Ratio - Item no. i			
Department or Unit Name	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**
CVU RN	1:2/3	1:2/3	1:2/3
CVU PCA	1:8	1:8 x 2 hrs	0
ICU RN	1:2	1:2	1:2
ICU PCA	1:20	1:20	0
Family Birthing Center (Post Partum-cuplets) RN	1:3-5	12 hour shifts	1:4-5
FBC Surgical Techs	1 not ratio driven	1 not ratio driven	1 not ratio driven
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven
Labor and Delivery RN	1: 1-2	12 hour shifts	1:1-2
Special Care Nursery RN	1:2-3	1:2-3	1:2-3
Well Baby Nursery RN	n/a	n/a	1:6
Telemetry RN	1:4-5	1:4-5	1:5-6
Telemetry PCA	1:8-9+monitor watcher	1:10+MW	1:10+MW
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+PT aid	1:10-12	1:10-12
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p	
Pomeroy 8 PCA	1*	1*	1*
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:6:7
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12
Emergency Department RN	C ore: 7/11	11	7/6
Emergency Department PCA	Core: 3/4	5	3/2

Projected Staffing Levels		
Average RN to Patient Ratio - Item no. ii		
Shift #1 AM	**Shift #2 PM**	**Shift #3 overnight**
1:2/3	1:2/3	1:2/3
1:2	1:2	1:2
1:3-4	12 hour shifts	1:4-5
1 not ratio driven	1 not ratio driven	1 not ratio driven
1: 1-2	12 hour shifts	1:1-2
1:2-3	1:2-3	1:2-3
n/a	n/a	1:6
1:4-5	1:4-5	1:5-6
1:5-6	1:5-6	1:6-7
1:5-6	1:5-6	1:6-7
1:6-8	1:6-8	1:8-12
Admit RN 11a-11p	Admit RN 11a-11p	
1:3-4	1:3-4	1:3-4
1:5-6	1:5-6	1:6-7
C ore: 7/11	11	7/6

FootNote - (1) Nursing staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.

Staffing Attachment I I

Projected Staffing Level FY 2017 - Year 2

Question No. 1 - Part b

Projected Staffing Levels			
Average Nurse (1) to Patient Ratio - Item no. i			
Department or Unit Name	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**
CVU RN	1:2/3	1:2/3	1:2/3
CVU PCA	1:8	1:8 x 2 hrs	0
ICU RN	1:2	1:2	1:2
ICU PCA	1:20	1:20	0
Family Birthing Center (Post Partum-cuplets) RN	1:3-4	12 hour shifts	1:4-5
FBC Surgical Techs			
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven
Labor and Delivery RN	1: 1-2	12 hour shifts	1:1-2
Special Care Nursery RN	1:2-3	1:2-3	1:2-3
Well Baby Nursery RN	n/a	n/a	1:6
Telemetry RN			
Telemetry PCA	1:8-9 + MW	1:10+MW	1:10+MW
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+PT aid	1:10-12	1:10-12
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p	
Pomeroy 8 PCA	1*	1*	1*
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:6-7
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12
Emergency Department RN	C ore: 7/11	11	7/6
Emergency Department PCA	Core: 3/4	5	3/2

Projected Staffing Levels		
Average RN to Patient Ratio - Item no. ii		
Shift #1 AM	**Shift #2 PM**	**Shift #3 overnight**
1:2/3	1:2/3	1:2/3
1:2	1:2	1:2
1 not ratio driven	1 not ratio driven	1 not ratio driven
1: 1-2	12 hour shifts	1:1-2
1:2-3	1:2-3	1:2-3
n/a	n/a	1:6
1:5-6	1:5-6	1:5-6
1:6-8	1:6-8	1:8-12
Admit RN 11a-11p	Admit RN 11a-11p	
1:3-4	1:3-4	1:3-4
1:5-6	1:5-6	1:6-7
C ore: 7/11	11	7/6

Staffing Attachment I I

Projected Staffing Level FY 2018 - Year 3

Question No. 1 - Part b

Projected Staffing Levels			
Average Nurse (1) to Patient Ratio - Item no. i			
Department or Unit Name	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**
CVU RN	1:2/3	1:2/3	1:2/3
CVU PCA	1:8	1:8 x 2 hrs	0
ICU RN	1:2	1:2	1:2
ICU PCA	1:20	1:20	0
Family Birthing Center (Post Partum-cuplets) RN			
FBC Surgical Techs			
Family Birthing Center (Post Partum-cuplets) PCA	1 not ratio driven	1 not ratio driven	1 not ratio driven
Labor and Delivery RN	1: 1-2	12 hour shifts	1:1-2
Special Care Nursery RN	1:2-3	1:2-3	1:2-3
Well Baby Nursery RN	n/a	n/a	1:6
Telemetry RN	1:4-5	1:4-5	1:5-6
Telemetry PCA	1:8-9+MW	1:10+MW	1:10+MW
Pomeroy 5 (Gen Med) RN	1:5-6	1:5-6	1:6-7
Pomeroy 5 (Gen Med)PCA	1:8-9	1:10-12	1:10-12
Pomeroy 7 (Neuro/Ortho)RN	1:5-6	1:5-6	1:6-7
Pomeroy 7 (Neuro/Ortho)PCA	1:8-9+PT aid	1:10-12	1:10-12
Pomeroy 8 (Behavioral Health)RN	1:6-8	1:6-8	1:8-12
Pomeroy 8 (Behavioral Health) Psych Tech	1:8-10	1:8-10	1: 8 - 12
Pomeroy 8 (Behavioral HealthMonday through Saturday)	Admit RN 11a-11p	Admit RN 11a-11p	
Pomeroy 8 PCA	1*	1*	1*
Behavioral Health ED RN	1:3-4	1:3-4	1:3-4
Pomeroy 9 (Gen Med/Surg) RN	1:5-6	1:5-6	1:5-6
Pomeroy 9 (Gen Med/Surg) PCA	1:8-9	1:10-12	1:10-12
Emergency Department RN	C ore: 7/11	11	7/6
Emergency Department PCA	Core: 3/4	5	3/2

Projected Staffing Levels		
Average RN to Patient Ratio - Item no. ii		
Shift #1 AM	**Shift #2 PM**	**Shift #3 overnight**
1:2/3	1:2/3	1:2/3
1:2	1:2	1:2
1: 1-2	12 hour shifts	1:1-2
1:2-3	1:2-3	1:2-3
n/a	n/a	1:6
1:4-5	1:4-5	1:5-6
1:5-6	1:5-6	1:6-7
1:5-6	1:5-6	1:6-7
1:6-8	1:6-8	1:8-12
Admit RN 11a-11p	Admit RN 11a-11p	
1:3-4	1:3-4	1:3-4
1:5-6	1:5-6	1:6-7
C ore: 7/11	11	7/6

EXHIBIT Q44-1

ANCILLARY CAREGIVER STAFFING ATTACHMENT (2015 AND PROJECTED)

FY-15 Staffing Hours			Projected Staffing Hours		
			FY-16	FY-17	FY-18
Item a.		Item b.	Item c.		
Department	Ancillary Care Provider	Avg. # hours /week care provided	FY 1	FY 2	FY 3
Cardiology	**Echosonographer**	72	104	104	104
Cardiology	**Stress Testing -Technician**	40	40	40	40
Cardiology	**Stress Testing - APRN**	30	70	70	70
Cardiology	**Cardiac Rehab- RN and Techs**	124	124	124	124
Pulmonary Function Lab	**Pulmonary Function Lab**	16	16	16	16
Radiology	**Radiology Technicians**	557	622	622	622
Radiology	**Ultrasonographers**	173	237	237	237
Radiology	**CT Technicians**	332	341	341	341
Radiology	**Interventional Radiology RN**	133	113	113	113
Radiology	**Interventional Radiology Technician**	130	130	130	130
Radiology	**Nuclear Medicine Technician**	87	87	87	87
Hemodyalisis Contracted Service	**RNs**	65	65	65	65
Emergency Department	**Physician Assistants**	210	210	210	210
Respiratory Therapy	**Respiratory Therapists**	644	644	644	644
Laboratory Services	**Laboratory Personnel**	1,642	1,642	1,642	1,642
Laboratory Services	**Phlebotomists**	575	575	575	575
Pharmacy	**Pharmacists**	590	590	590	590
Rehabilitation	**Physical Therapists**	211	211	211	211
Rehabilitation	**Physical Therypy Assistants**	90	90	90	90
Rehabilitation	**Occupational Therapists**	12	12	12	12
Rehabilitation	**Occupational Therapy Assistant**	26	26	26	26
Rehabilitation	**Speech Therapists**	39	39	39	39
Sleep Laboratory	**Sleep Lab Personnel**	240	240	240	240
Cardiac Diagnostics	**APRN**	40	40	40	40
Cardiac Diagnostics	**Anticoagulation Specialist**	64	64	64	64
Cardiac Diagnostics	**Anticoagulation Clinician**	24	24	24	24
Cardiac Diagnostics	**Nuclear Medicine Technician**	70	70	70	70
Cardiac Diagnostics	**Echosonographer**	80	80	80	80
Cardiac Diagnostics	**Stress Testing RNs**	80	80	80	80
Cardiac Diagnostics	**Medical Assistants**	128	128	128	128
EEG	**EEG Technologists**	70	70	70	70
Hospitalists Program	**Physician**	476	588	588	588
Hospitalists Program	**Physician Assistants**	112	120	120	120
Orthopeadic Program	**Physician Assistants**	280	280	280	280
Surgical Program	**Physician Assistants**	N/A	-	-	-
Gasteroenterology	**RNs**	184	184	184	184
Gasteroenterology	**GI Techs**	72	72	72	72
Outpatient Medical Therapy	**RNs**	160	160	160	160
Catheterization Lab	**Cath Lab RNs**	160	160	160	160
Catheterization Lab	**Cath Lab Techs**	160	160	160	160
Operating Room	**RNs**	600	600	600	600
Operating Room	**Surgical Techs**	420	420	420	420
Post Anesthesia Care Unit	**RNs**	240	240	240	240
One Day Surgery	**RNs**	470	470	470	470
One Day Surgery	**PCAs**	178	178	178	178
Food and Nutrition	**Clinical Dietician**	104	104	104	104

FootNote - (1) Nursing staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.

EXHIBIT Q47-1

PMH STATEMENTS OF DEFICIENCY AND PLANS OF CORRECTIONS

PMH Response to Question 47
Summary of Statements of Deficiency/ Plans of Correction
PMH-Owned Rhode Island Hospital Facilities

ST. JOSEPH HEALTH SERVICES OF RHODE ISLAND – COMPLAINT VALIDATION SURVEY

On June 23, 2014, a complaint validation survey at St. Joseph Health Services of Rhode Island was completed by the Rhode Island Department of Health (the "DOH"). Several deficiencies were noted involving the failure to implement hospital policies for "Medical Marijuana;" "Documented Informed Consent for AIDS/HIV and Confidentiality;" "Patient Search Policy;" "Constant Observation;" "Universal Protocol Policy;" "Annual Performance Competency Review Process;" and failure to report reportable incidents, in writing, to the DOH within 72 hours of incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

ST. JOSEPH'S HEALTH SERVICES OF RHODE ISLAND – COMPLAINT VALIDATION SURVEY

On March 6, 2013, a complaint validation survey was completed by the DOH. Several deficiencies were noted involving the failure to implement hospital policies for "Constant Observation;" "Fall Precaution Policy;" failure to provide care, in accordance with community standard, for bowel care; failure to ensure less restrictive interventions and/or alternatives had been employed and ineffective prior to chemically restraining a patient; and failure to report reportable incidents, in writing, to the DOH within 72 hours of incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

ROGER WILLIAMS MEDICAL CENTER – COMPLAINT VALIDATION SURVEY

On August 20, 2013, a complaint validation survey was completed by the DOH. Several deficiencies were noted to include failure to report reportable incidents, in writing, to the DOH within 72 hours of incident; failure to perform peer review on a reportable incident; and failure to submit a follow-up report to the DOH following a reported incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

St. Joseph Health Services of Rhode Island

200 HIGH SERVICE AVENUE
NORTH PROVIDENCE, RI 02904
(401) 456-3000

WWW.SAINTJOSEPHRI.COM

August 29, 2014

Raymond Rusin, Chief
RI Department of Health,
Division of facilities Regulation
3 Capitol Hill
Providence, RI 02908
In Hand

Re: HOS00110, survey completed 6/23/2014

Dear Mr. Rusin:

Enclosed please find Prospect CharterCARE SJHSRI's Plan of Correction for citations received on August 15, 2014, in the Statement of Deficiencies from the Rhode Island Department of Health, for a visit May 22, 2014 through June 23, 2014.

Sincerely,

Thomas Hughes, FACHE
President
Prospect CharterCARE SJHSRI
200 High Service Ave
North Providence, RI 02904
Attachment

cc Catherine Lynn, RN

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING: _____ B. WING _____	C 6/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

(X) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC INDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 0	INITIAL COMMENTS A State complaint investigation survey, a follow-up (*EJ0011, 6/20/14) to previous State complaint investigation survey, and an 'Other' State licensure survey (DDWN11, 6/20/14) were conducted at this facility. Prior deficiencies are recited, and deficiencies relative to the State complaint investigation survey and the 'Other' State licensure survey are also cited.	Z0		
Z 160	ORGANIZATION & MANAGEMENT 12.2 Organization 12.2 Each hospital department and service shall maintain: a) clearly written definitions of its organization, authority, responsibility and relationships; b) written patient care policies and procedures; and c) written provision for systematic evaluation of programs and services. This Requirement is not met as evidenced by: Based on record review, staff interview, and review of hospital policies, it has been determined that the hospital failed to implement the following policies: 1. "Medical Marijuana", for 1 of 1 relevant sample patients, ID #4; 2. "Documented Informed Consent For AIDS/HIV and Confidentiality", for 5 of 5 relevant sample patients, ID#'s 6, 39, 40, 41 and 42; 3. "Patient Search Policy", for 1 of 1 relevant sample patients, ID #18; 4. "Constant Observation", for 3 of 4 relevant sample patients, ID #'s 2, 27, and 34; 5. "Universal Protocol Policy", for 1 of 6 relevant	Z 160		

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Z 160	Continue From page 1 sample patients, ID # 26; 6. "Annual Performance Competency Review Process", for 6 of 12 relevant sample employees, ID's A, B, C, D, E and F. Findings are as follows: I.The hospital policy, "Medical Marijuana", dated 10/2012, under "Policy Statement" states, under item b: "If the patient is determined to be a licensed card holder, the material in question will be sent home with the patient or the patient's family. In the event that no family members are available to receive the material, it will be disposed of and destroyed…The pharmacist will contact the patient's prescriber to recommend Marinol (dronabinol) as an oral, FDA (Food and Drug Administration) approved alternative medication to use while the patient is admitted." Review of the clinical record for patient ID #4 reveals that the patient was admitted to the hospital on 3/14/13 for a psychiatric evaluation. The patient presented with a Medical Marijuana Card, and a small amount of marijuana. The patient told staff that there was no significant other to remove the marijuana from the facility, therefore the marijuana was disposed of in the presence of the patient and pharmacy staff in accordance with hospital policy. The record lacked evidence that the patient's physician was contacted by a hospital pharmacist to recommend Marinol during the patient's admission in accordance with the hospital policy.	Z 160	**I. Hospital Policy: Medical Marijuana (#04-953-281)** a. Members of Pharmacy staff will complete and read & sign the above policy and related departmental specific notes of process. **MOS: 100% compliance.** Signature pages will be submitted to Risk Mgt. b. RNs (hospital) will complete read & sign of above policy and departmental specific notes of process. **MOS: 100% compliance.** Read and sign recording will be kept electronically by Nsg Ed. A report will be generated & submitted to Risk Mgt (staff who performed the read & sign.) c. Security Guards will complete a read & sign of above policy and departmental specific notes of process. **MOS: 100% compliance.** Signature pages will be submitted to Risk Mgt. d. **Audit:** All charts of patients admitted with Medical Marijuana will be audited for 6 months to determine compliance with hospital policy and appropriate documentation of intervention & notification to Dir/Mgrs Pharmacy. If goal achieved, a determination will be made as to need for further audits. **MOS: 100% compliance.**	**Pt Safety/ Ethics & P & T Committees** 9/30/2014 10/15/2014 10/15/2014 11/1/2014 – 5/1/2015

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 160	Continued From page 2 During an interview on 5/27/14 at approximately 2 PM with the Lead Operational Pharmacist, who was present when the marijuana was destroyed, it was revealed that contact with the patient's physician regarding prescribing Marinol did not occur. II. The hospital policy, "Documented Informed Consent for AIDS/HIV and Confidentiality", dated 3/2011, under "Policy", item A states: "AIDS tests will only be done with the documented informed consent of the patient..." A review of the clinical record for patient ID #6 reveals the patient was admitted to the facility on 8/2/13 with a question of stroke. While in the hospital the patient had blood work completed which included testing for HIV (human immunodeficiency virus). The medical record lacked evidence of documentation of an informed consent of the HIV testing in accordance with hospital policy. When interviewed on 6/12/14 at approximately 8:30 AM, the ordering physician revealed, "I may have discussed the HIV testing with the patient, but I did not document it; there is an informed consent policy, I usually write it in the record." Review of 4 additional relevant clinical records for patient ID #s 39, 40, 41 and 42 revealed no evidence that informed consent for HIV testing had been obtained in accordance with hospital policy.	Z 160	**II. Hospital Policy: "Documented Informed Consent for AIDS/HIV & Confidentiality" (#04-711-41 aka IP & IC Manual A-2b)** a. Revise above policy to include required HIV Consent Form to be completed by ordering MD/LIP & signed by MD/LIP & patient. Prepare & attach a new HIV Consent Form to be used (available in Meditech.) Add a verification process for completion of above Consent Form & counseling/education prior to HIV test order to be placed in Meditech & accepted. **MOS: Completion of Policy revisions & prepare Consent Form by 10/1/14.** Once above policy is completed, the HIV (Aids) Tests Umbrella Plan IP & IC Manual A-2f will be revised accordingly. b. Create stop gap in Meditech to prevent HIV testing without compliance with policy requirements. **MOS: Completion in Meditech 10/15/14 to begin 11/15/14.** c. Focused physician and healthcare worker education in high volume areas re: policy revisions & stop gap. Areas include: ED, BH, SJHSRI clinics, & Infectious Disease: • MDs/LIPs & MD (involved in citation) • Nurses & Unit secretaries - Skills Fair • SJHSRI Clinic (RN, LPN, MA, Unit secretaries) – Skills Fair **MOS: 100% completion by high volume**	**Patient Safety Committee** 10/1/2014 10/15/2014 10/15/2014 – 11/15/2014

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Z 160	Continued From page 3 III. The hospital policy, Patient Search Policy", dated 8/2010, under "Procedure", Item II, "Patient Search" states: "A patient search is performed by two people in the following circumstances: any patient who demonstrates symptoms which suggests the use of contraband drugs." "The patient search is performed as follows": Item b. "The patient removes clothes and will be placed in a hospital gown and the staff member searches the clothing item…" Review of the clinical record for patient ID #18 revealed that the patient was brought to the ED (emergency department) by EMS (emergency medical services). The patient had been found in respiratory arrest after injecting heroin. The patient regained consciousness after treatment. The physician's clinical impression was "heroin overdose". While being monitored in the ED, the patient became unresponsive. The patient responded to	Z 160	**MDs/LIPs, MD involved in citations & healthcare workers of above areas.** Sign-in sheets/report will be submitted to Risk Mgt. d. **Audit:** All HIV orders entered into Meditech (answer: yes & no) will be reviewed monthly for 3 months. If healthcare worker has to contact MD/LIP for consent, it will be tracked & MD/LIP will be re-educated. If compliance goal is reached, a random audit will continue as appropriate. **MOS: 100% compliance.** **III. Hospital Policy: "Patient Search" (C- 52)** a. Revise above policy to eliminate "Emergency Department", as searches will be detailed in a newly created Risk Assessment Policy & obtain approval. **MOS: Policy will be revised.** b. Draft policy "Emergency Risk Assessment for Behavioral Health Patients" (Risk Assessment Policy) & attached "Emergency Risk Assessment Guide." Risk Assessment to be completed by MDs &/or ED Clinicians - for all patients presenting with psychiatric concerns, substance abuse issues, detox requests &/or overdoses. To be piloted in ED before final approval. **MOS: Pilot implemented.** c. Risk Assessment created in Meditech for ED Clinicians and ED RNs to access & document on patients that meet the policy requirements. **MOS: Risk Assessment completed in Meditech.** d. Risk Assessment created in the EMR for MDS/LIPs to access & documentation on patients that meet policy requirements. This documentation comes with color coding in Meditech & with visual representation	12/1/2014 – 2/1/2015 **Patient Safety Committee** 9/30/2014 Pilot began 6/1/2014 – 10/1/2014 Clinicians: 8/18/2014 RNs: 10/30/2014 8/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 160	Continued From page 4 treatment. The physician's note reveals, "Patient states s/he found a bag of drugs on the way to the bathroom and used them in the bathroom. Patient still has pants on so it is possible that something was in a pocket..." When interviewed on 6/17/14 at approximately 11:30 AM, the ED Chief revealed, "I feel the care was not optimal, the patient should have been searched." It was determined that the patient was allowed to keep pants on while wearing a hospital gown, and a search for contrabands had not been performed in accordance with the hospital policy. IV. The hospital policy, "Constant Observation", dated 6/2013, under "Policy" states:	Z 160	outside patient's rooms for staff awareness of risk level. **MOS: Risk Assessment completed in EMR.** e. Emergency Risk Assessment Guide will be posted in LSU & Core of ED – quick reference. f. Education provided on above pilot policy & Emergency Risk Assessment Guide for: • ED Clinicians (also documentation) • ED MDs/LIPs (also documentation) • ED RNs • ED CNAs • Security guards **MOS: 100% compliance.** Signature sheets/reports of attendance of all will be submitted to Risk Mgt. For staff who float to the ED, a just in time read & sign will be used. g. Final revision & approval of Risk Assessment Policy - apply to ED. h. **Audits:** Review of completions of the Risk Assessments performed in the ED: • All Risk Assessments completed by ED Clinicians will be reviewed by Access Manager/Lead Clinician for 6 months. If goal achieved, random audits will be determined. • 30 Risk Assessments completed by MDs/LIPs will be reviewed by ED MDs monthly for 3 months. If goal is achieved, random audits will be determined. **MOS: 100% compliance with new Risk Assessment Policy.** **IV. Hospital Policy "Constant Observation" (N-7)**	9/1/2014 8/13/2014 10/1/2014 9/30/2014 9/30/2014 9/30/2014 11/30/2014 12/1/2014 – 5/1/2015 12/1/2014 – 3/1/2015 **Patient Safety Committee**

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Z 160	Continued From page 5 "It is hospital policy to institute a level of Constant Observation for the patient who manifests one or more of the following criteria": Item #2 "Imminent threat to physical or emotional well-being including but not limited to: Reported suicidal/homicidal ideation's." Under, "Definitions", it states: "Constant observation – process of visually monitoring (observing) a patient at all times, regardless of patient activity; goal is to prevent patient from leaving hospital and from causing injury to self or others; may be used with or without patient being in physical restraints." Under, "Procedure", item 5b it states: "Remain with the patient at all times including bathroom visits (door will be left cracked with consideration for privacy but must be visual) and when patients appear to be sleeping focus on visibility of mouth and hands, maintain no more than arms length distance unless otherwise directed..." 1. Review of clinical record for patient ID #2 revealed that the patient was on 1:1 observation. On 4/9/14 at approximately 7:30 AM, the patient could not be found. A search was conducted and the patient was found unharmed at approximately 8:00 AM, in a lower cabinet in the television room. During an interview on 5/28/14 at approximately 3 PM with the Director of Behavioral Health, it was revealed that the person who was assigned to	Z 160	a. Draft Risk Assessment Policy, as well as Meditech and EMR Risk Assessment documentation. Referred to in III a - e. Risk Assessment to be piloted in ED before final approval. Risk Assessment - addresses complex situations (sexual trauma, psychosis & complex grief.) ED to practice Trauma-Informed Care – allow patients self-determination, if appropriate, ability of patient to contract for safety (CFS) with psychiatrically-trained clinician. Risk Assessment addresses: disrobement, searches, medications, restraints & patient's ability to CFS thus negating need for 1:1 observation. b. Education concerning Risk Assessment Policy & documentation is discussed above in III f. c. Final approval of new Risk Assessment Policy - see III g. above. d. Edit and complete revisions of Constant Observation Policy (N-7) to reflect new Risk Assessment Policy," since Risk Assessment will address clinical needs of patient & determine the patient's immediate needs {medication, restraints, disrobement (forcible or not) after negotiations, as well as need for 1:1 or patient's ability to CFS. If patient is able to CFS in ED, then a 1:1 observation will not be required.} In addition, the Constant Observation 1:1 Report Form attached to policy was revised 6/5/2014 to meet the needs of BH Units to provide an increased level of communication between RN & constant observer to better meet patient's needs. It identifies specific behaviors & effective interventions, enhancing & encouraging	a. See III above b. See III above c. See III above d. 9/2/2014 - 10/14/2014

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Z 160	Continued From page 6 the constant observation monitoring of the patient went to assist other staff when another patient had fallen. It was at this time that patient ID #2 was left unattended. The hospital investigation determined that based on the review of surveillance video, the patient was in the lower cabinet for approximately 27 minutes. 2. Review of the clinical record for patient ID #27 revealed that the patient presented to the ED after an attempted drug overdose. The patient has a psychiatric history of greater than 20 suicide attempts. The documented patient complaint was "major depression and suicidal ideas". The patient was triaged and placed in Room 7. The plan was for the patient to have a psychiatric evaluation. At approximately 11:55 AM, the patient eloped from the ED. A search by security staff found the patient standing at a bus stop across the street from the hospital. The patient was safely brought back to the hospital ED, and placed in the LSU (low stimulus unit) on 1:1 observation. During an interview on 6/16/14 at approximately 9 AM, the Risk Manager revealed that with hospital investigation the triage nurse had reported that the LSU was full when the patient arrived. It was also reported that the patient should have been on a 1:1 upon arrival to the ED, but there was not enough staff and no bed available in the LSU. When interviewed on 6/18/14 at approximately 1:30 PM, the ED nurse who cared for the patient revealed that the patient stated s/he wanted to	Z 160	therapeutic rapport between constant observer and the patient. This will become part of the policy for all units. e. Due to new ED policy concerning Risk Assessment, described above, the following policies will be revised & approved: • N-7 Constant Observation • N-19 Suicide Precautions • N-21 Elopement. f. Education of policy revisions of N-7, N-19 & N-21 for RNs & CNAs: • Mandatory Skills Fair. **MOS: 100% compliance with attendance with the exception of those who are on LOAs from the organization.** Sign-in sheets or Reports on attendance will be submitted to Risk Mgt. g. Any ED patient requiring a psychiatric evaluation is no longer allowed to use the hallway bathroom with 2 exit doors (in the core) but instead must use the bathroom in LSU. h. **BH Units (including 3 South, Geri Psych Unit):** Education of clinical staff on Constant observation policy and Constant Observation Report Form as follows: • CNAs educated at CNA skills Fair • BH Staff (RNs & CNAs) at Mandatory BH Skills Fair **MOS: 100% compliance with attendance.** Sign-in sheets or Report of attendance will be submitted to Risk Mgt. Any staff that does not attend by said date must complete training through Nsg Ed intranet with competency exam. Sign-in sheets to be submitted to Risk Mgt.	9/2/2014 – 10/14/2014 10/15/14 – 10/31/2014 5/1/2014 6/26/2014 7/2/2014 8/29/2014

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Z 160	Continued From page 7 commit suicide. However, the patient was left in a room without 1:1 supervision, reportedly due to a lack of sufficient staff. 3. Review of the clinical record for patient ID# 34 reveals the patient was brought to the ED via EMS for making suicidal statements to his/her father. The patient has a past suicidal attempt in December of 2013. Review of the triage notes reveals the patient did express feelings of depression and thoughts of harming self. The patient was placed on suicide precautions and 1:1 observation. At approximately 2:15 AM the patient was accompanied to the bathroom by the registered nurse. While in the bathroom, the patient opened the other door to the bathroom and fled the ED. The local police were notified, found the patient, and brought him/her back to the ED. During an interview on 6/18/14 at approximately 10 AM with the Risk Manager, she revealed the patient was placed in the "core" area of the ED on arrival. A hallway bathroom was used that has 2 doors, one of which goes to the waiting area. Surveillance video shows the patient was escorted to the bathroom by the RN. The patient was allowed to close the door completely, putting the patient out of view of the RN and security officer. The patient then fled out of the other door leading to the waiting area. The patient was not in full view of staff in accordance with the hospital policy.	Z 160	i. **BH Units:** Educational program developed for BH Skills Fair will be reviewed during BH orientation for new hires. Also on the intranet. j. **3 South Audit:** Documentations of all patients on 1:1 observation will be reviewed for 3 months for compliance; then documentation of 50% of patients who are on 1:1 observation will be reviewed for compliance and will continue to be audited until goal is reached. **MOS: 100% compliance.** k. Hire consultant & hospital staff (ED & 3 South) to participate in RCA & corrective action plan on constant observation of patients	8/29/2014 8/1/2014 – 11/1/2014 11/1/2014 until compliance is reached. Submit name to DOH – await approval

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Z 160	Continued From page 8 V. The hospital policy, "Universal Protocol Policy", dated 9/2012, under "Marking the Operative Site", states: "All patients having an invasive procedure/surgical procedure that involve laterality...will have their site marked." "The surgeon will mark the site with his initials. The exception to this is Spinal level, which will be completed as follows: Skin marked at the level of the procedure (e.g. cervical, thoracic, lumbar) The skin mark indicates anterior vs. posterior and right vs. left." Under, "Time-out Process," it states: "An incision will not be made until the circulating nurse or procedure assistant and physician/dentist together along with the SRNA/CRNA/Anesthesiologist (student registered nurse anesthetist/certified registered nurse anesthetist) (if appropriate) actively verifies the surgical information. The physician will initiate "time-out" for the verification process. All staff involved in the procedure (Physician, Anesthesia, Circulating Nurse, Scrub Tech) will pause, take a time-out to verify: The correct patient The correct procedure Correct site/side (confirmed with consent by RN/licensed provider) Physician's initials on procedure site/side visible after prepping and draping, can we see the mark?"	Z160	**V. Hospital Policy: "Universal Protocol" (#04-953-130)** a. Education completed re: Universal Protocol and forms used provided to Radiology Staff. **MOS: 100% compliance** Copies of sign in sheet provided to Risk Management. b. Same education provided to 4 Radiologists (who perform IR procedures.) c. Hospital wide Universal Protocol in-service which Includes: PowerPoint presentation, handouts & post test. **MOS: 100% mandatory attendance by Anesthesia & Diagnostic Imaging Depts and 100% completion of post test.** Sign-in sheets & post tests to be submitted to Risk Mgt. Also invited to attend: OR staff, ED, Critical Care, Endoscopy & other areas of the hospital. d. Mandatory Universal Protocol in-service will be provided to new anesthesia group - sub contractor – anticipated start date 12/2014. **MOS: 100% compliance with attendance & completion of post test.** Sign in sheet & post tests submitted to Risk Management. e. Mandatory Universal Protocol in-service to be part of orientation in the following clinical areas: Diagnostic Imaging, OR, & Endoscopy. **MOS: 100% compliance with attendance & completion of post test.**	**Patient Safety Committee** 10/14/2013 10/2013 9/10/2014 Anticipated 12/2014 10/1/2014

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Z 160	Continued From page 9 Review of the clinical record for patient ID# 26 reveals on 5/22/13 the patient underwent a lumbar and sacral dorsal rami block for right lower back pain. The procedure documentation reveals, "Left L5 (lumbar) and sacral L1, L2, L3 and L4 dorsal rami block." The procedure documentation by the physician revealed that at the conclusion of the procedure, it was realized that a left sided injection was performed. This was done despite documentation in the patient's history and physical that his/her pain was principally right sided. Informed consent was for a right sided injection. It was confirmed with the patient that the right side was to be done. Review of the Procedure Assessment/Plan lacks evidence that the site was verified and marked. During an interview on 6/13/14 at approximately 12:15 PM, the Risk Manager revealed in the hospital investigation that it was realized that those involved in the procedure did not actively participate during the time-out. During the time-out, the radiological technician and physician had started the procedure, and the nurse was doing paperwork. There were no site markings in accordance with hospital policy. Additionally, the "Universal Protocol checklist Non-Operating Room" documentation was not used. When interviewed on 6/17/14 at approximately 12:30 PM, the Chief of Anesthesia revealed the site should have been marked per hospital protocol. During the time-out, everyone is to stop what they are doing and listen to the physician at this time; all in the room should participate during	Z160	f. When applicable, mandatory Universal Protocol in-service will be provided to new professional service groups as their contracts commence g. **Audit:** All needle puncture procedures in Special Procedures, Interventional Radiology, Mammography & Ultrasound will be completed monthly for compliance with the policy for 6 months. If goal is achieved random auditing will be determined. **MOS: 100% compliance.**	Anticipated 1/2015 11/1/2014 – 5/1/2015

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Z 160	Continued From page 10 the time out. During an interview on 6/18/14 at approximately 2:20 PM, the Radiological Technician revealed, "when we do a time out or briefing we should all be in the room. I was not in the room when the time-out was done; I was in the control room entering patient information into the computer." The physician and the nurse were in the room and did the time-out without the technician being present. VI. The hospital policy, "Annual Competency Based Evaluation System", dated 7/2010, under "Procedure" item B states: "It is the responsibility of the department manager/supervisor to document performance and assess competency on an ongoing basis on an evaluation and meet with their employees as soon as possible." Also, review of the hospital policy dated 4/2013, entitled "Annual Performance Competency Review Process," under "Policy Statement," states: "A documented annual Performance Review is required of all CharterCARE Health Partner employees in a budgeted position, employees in a per diem position who work 350 or more hours in a year, as well as contracted staff and volunteers..." Review of 6 out of 12 employee files lacked evidence of an annual performance evaluation, (Employee ID's A, B, C, D, E and F).	Z160	**VI. Hospital Policy: "Annual Competency Based Evaluation System" (#HR-600-00021-0)** a. All evaluations for non-union employees - due by October 30th each year. All Evaluations for union employees are completed by employee anniversary date. **MOS: 98% compliance for 2013.** b. Managers have ability to access compliance report in Meditech. In addition, HR Generalists will send out reminders on a bi-weekly basis. **MOS: HR reminders will be sent to Managers biweekly starting 8/29/2014.** c. Revise above policy to include Performance Improvement Process (PIP.) **MOS: Policy revisions completed by 9/1/2014.** d. HR will provide mandatory training sessions for all of leadership on: • 4 step performance review process	**Members of Prospect CharterCARE Sr Leadership/ & BOT** Effective October 2013 Immediately Start 8/29/2014 9/1/2014 9/30/2014

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Z 160	Continued From page 11 ID's A & B lacked an annual performance evaluation for 2012. ID C lacked an annual performance evaluation for 2011 and 2012. ID's D & F lacked an annual performance evaluation for 2012. ID E lacked an annual performance evaluation for 2012 and 2013. When interviewed on 6/4/14 at approximately 2:30 PM, the Vice President of Human Resources revealed that the policy is for annual evaluations, and efforts have been made over the years to enforce this policy.	Z 160	◦ Utilization of Meditech for accessing reports on compliance with performance reviews. **MOS: 100% compliance with attendance.** Sign – in sheets to be submitted to Risk Mgt. e. Corrective actions will be issued to Mgrs/Supervisors/Dirs who are not in 100% compliance after 10/30/2014, as well as hold their merit, if applicable. **MOS: 90% compliance** **Audit:** Compliance reports will be updated monthly. Copy of audit reports will be submitted to Risk Mgt. HR will provide the corrective action template and recommendations to Dir/VP accordingly. PIPs issued will be submitted to Risk Mgt for continued tracking.	12/30/2014
Z940	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on document review and staff interview, it has been determined that the hospital failed to report, in writing to the licensing agency, reportable incidents within 72 hours for 5 of 18 relevant sample patients (ID#'s 26, 29, 30, 36 and 38).	Z940	**Patient Care Services 34.8 Reportable Incidents** a. Identify units involved in citation (late reporting) in RL 6 & to Risk Mgt (pager) (for specific events/harm levels) & reasons. **MOS: Complete identification.** b. Review past DOH reporting audits 8/1/2013 – 7/1/2014 to identify: units involved & common reasons for late reporting. **MOS: Complete list of reasons.** c. Speak with members of Nursing Safety Council about (late reporting) to determine reasons & obtain suggestions for easier frontline reports. Include suggestions in further education & changes.	**Patient Safety Committee** 8/19/2014 9/30/2014 9/30/2014

Facilities Regulation
PROVIDER REPRESENTATIVE'S SIGNATURE Thomas Hughes TITLE President, Prospect CharterCARE SJHSRI (X6) DATE

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Z940	Continued From page 12 Findings are as follows: 1. A reportable incident occurring for patient ID# 26 on 5/22/13 was not reported to the licensing agency until 5/28/13. 2. A reportable incident occurring for patient ID# 29 on 12/30/13 was not reported to the licensing agency until 1/7/14. 3. A reportable incident occurring for patient ID# 30 on 11/7/13 was not reported to the licensing agency until 11/18/13. 4. A reportable incident occurring for patient ID# 36 on 10/31/13 was not reported to the licensing agency until 11/6/13. 5. A reportable incident occurring for patient ID# 38 on 12/8/13 was not reported to the licensing agency until 1/30/14. During an interview on 6/20/14 at approximately 1:30 PM with the Risk Manager, she was unable to provide evidence that the above incidents were reported to the licensing agency within 72 hours as required, and indicated that she frequently gets these reports late from staff.	Z940	d. Hire consultant & participate in RCA & corrective action plan on timely reporting to DOH. e. Educate clinical staff on units identified re: positive, non-punitive aspect of RL 6 & use of RL 6 to promote culture of safety; near miss events - importance of entering near misses, learning tool & way to improve safe patient care; types of events to report & importance of timely reporting. o How to enter an RL 6 report, necessary information needed & how to classify harm. o Types of events to report (specific examples for specialized depts), circumstances Risk Mgt should be paged & include examples of "Near Misses" where incidents have been prevented by RL 6 reporting. **MOS: 90% compliance in attendance.** f. Create mandatory education packet for clinical staff concerning types of events to report in RL 6, timeliness of reporting & severity scores to be completed during orientation along with post-test. Work with Nsg Ed on integration of this mandatory education into clinical orientation & to be tracked with all mandatory orientation requirements. g. Work with Nsg Ed re: training of clinical staff during nsg orientation on how to enter an RL 6 & the plan for implementation. h. Risk Mgt to create list for leaders & clinical staff on when Risk Mgt should be paged (event types & particular severity levels) & provide to Mgrs. **MOS: Complete list.**	Submit name to DOH - await approval 10/30/2014 11/30/2014 12/1/2014 11/30/2014 9/30/2014

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Z940	Continued From page 13	Z940		
			i. In addition to Risk Mgt's usual availability to support leadership with RL 6 technical issues Risk Mgt will schedule quarterly meetings with Mgrs/Directors/various Nursing Practice Councils to support & assist staff with RL 6. **MOS: 100% compliance with scheduling mtgs.**	12/1/2014
			j. Explore with RL Solutions whether Risk Mgt staff can receive automatic notification via email if an RL 6 is entered with severity level of E or greater. If so, change profiles of Risk Mgt staff.	9/30/2014
			k. **Audit:** All reporting to DOH will be reviewed for date & timeliness reported in RL 6; how Risk Mgt was notified, date report sent to DOH & timeliness; if not timely DOH report, why – RM, unit or other issue; & specific reason. Copies of audit findings will be sent to Mgrs/Directors, Practice Council Steering Committee, CNO & President.	9/30/2014 – 3/30/2015
			MOS: All units will be at 100% compliance with on time reporting in RL 6 & to RM.	3/30/2015
			MOS: Risk Mgt will be at 100% compliance with reporting to DOH.	3/30/2015

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St. Joseph Health Services of Rhode Island

WWW.SAINTJOSEPHRI.COM

200 HIGH SERVICE AVENUE
NORTH PROVIDENCE, RI 02904
(401) 456-3000

April 22, 2013

Raymond Rusin, Chief
RI Department of Health, Division of Facilities Regulations
Three Capitol Hill
Providence, RI 02908
In Hand with Return Receipt

RE: HOS00110, survey completed 3/6/2013

Dear Mr. Rusin:

Documents:

Enclosed please find St. Joseph Health Services of RI's Plan of Correction for citations received in the Statement of Deficiencies from the Rhode Island Department of Health for a survey beginning on January 22, 2013 that was completed March 6, 2013.

In addition, I would like to acknowledge Madeline Vincent & her staff who will be meeting with Pat Nadle on Thursday, April 25, 2013 to enhance our attached Action Plan.

Sincerely,

Kenneth Belcher
President & CEO
St. Joseph Health Services of RI

Attachment

cc: Madeline Vincent
Michael Conklin
Kim O'Connell, Esquire
Patricia Nadle

Hand deliver to Raymond Rusin, Chief, Action Plan for HOS00110, survey completed 3/6/2013 on Monday, April 22, 2013.

Ashley Powers

NAME

4/22/13

DATE

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Z 0	INITIAL COMMENTS A State complaint investigation survey, an "Other" State survey (1ON111, 3/06/13), and a follow-up to a State complaint investigation survey (*J07112, 3/06/13) were conducted at this facility. Prior deficiencies were recited and deficiencies were cited relative to the State complaint investigation and the "Other" State survey.	Z0	**In order to maintain gains for all ongoing monitoring below, adjustments of Action Plans will be made as necessary.**	
Z 160	ORGANIZATION & MANGEMENT 12.2 Organization 12.2 Each hospital department and service shall maintain: a) clearly written definitions of its organization, authority, responsibility and relationships; b)written patient care policies and procedures; and c) written provision for systematic evaluation of programs and services. This Requirement is not met as evidenced by: cBased on record review, staff interview , and review of hospital policies, it was determined that the hospital failed to implement the policy entitled "Constant Observation" for 1 of 3 relevant sample patients (ID #'s 8, 15, 29, 30 and 32). Findings are as follows: 1. A review of the hospital policy entitled "Constant Observation," under "Policy" states: "It is hospital policy to institute a level of Constant Observation for the patient who manifests one or more of the following criteria: Imminent threat to physical or emotional	Z 160	**<u>Elopement of SI Pt on Constant Observation:</u>** 1. ED will utilize a CNA identified from the CNA pool, who will to fill the role of constant observer 24/7, if needed. **MOS: Target 100%** -Confirm availability and utilization of CNA as constant observer from staffing sheets for 1 mth. 2. Review & revise Constant Observation Policy #N-7 in conjunction w/ Suicide Precautions Policy #N-19 & Elopement of Patients Policy # N-21 (along with Security Elopement policy #E-002) to meet best practice guidelines and will include but not be limited to: (define 1 to 1 v. line of site & other types of observation; remove contradictions from policy; add section for non-clinical observer; revise decision algorithm; & develop consistent documentation tool to be utilized by constant observer.) 3. Education of revisions of N-7, N-19, & N-21 for all areas that may have a pt on constant observation: {ED, Housewide	5/31/13 Pt. Safety: 6/13/13 5/31/13 6/30/13

Facilities Regulation

Kenneth Allden President/CEO 4/22/13

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Z 160	Continue From page 1 well-being (Suicidal or Violent Behavior Precautions) including but not limited to: Reported suicidal/homicidal ideation's." Under ""Procedure" it states: "At no time should the patient be left alone or unobserved (exception: diagnostic testing)" A review of the clinical record for patient ID #49 revealed that the patient was transported to the hospital via EMS (Emergency Medical Services) for a psychiatric evaluation after a hanging attempt. The patient was evaluated by behavioral health services, and the case was discussed with a hospital psychiatrist. It was determined that the patient would be admitted for suicidal ideation. Physician's orders while in the ED revealed the patient to be placed on "one to one" constant observation. A review of the ED physician's note revealed "Appropriate security watch urgently ordered by me after the patient's arrival in ED; patient is a potential danger to self." Review of the ED documentation revealed that at approximately 9:30 AM the patient eloped from the hospital. The police were notified, and the patient was located and returned to the hospital. During an interview on 2/21/13 at approximately 9:30 AM with the Director or Security; he reported that the SO (Security Officer) assigned to constant observation of the patient was "watching 3 rooms at that time". He further reported that the patient was on constant observation for suicidal and elopement risk, and "should have been 1:1 with the officer". Additionally, the officer should not have been watching other	Z 160	(include per diem & float staff RNs, CNAs & MHWs), & Security.) **MOS: 90 - 100% Compliance**–Read & Sign policies which will be documented in API tracking software. 4. Develop annual mandatory competency for constant observation re: role, intention, requirements & documentation. This competency will be completed by: All ED staff, security, & float staff who work in ED. **MOS: 90-100% Compliance** - Completion of competency. **MOS: 100% Compliance** **Audit 100% charts/ mth for 3 mths** to determine if suicidal/homicidal pts are actually placed on constant observation & documentation complete. Also, audit all elopements from ED to insure no pts were SI/HI or certified at time of elopement for 3 mths. 5. All ED staff will complete 8 hrs of CPI training initially & recert thereafter: (RNs, CNAs, Security, & Float Staff). Plan developed to insure new staff hired to work in ED will be trained w/in 3 mths of hire. **MOS: 100% Compliance** Current staff will successfully complete 8 hrs of CPI training **50% by 6-30-13; 75% by 7-31-13; & 100% by 12-18-13.** 6. Low Stimulus Unit (LSU) will be adequately staffed to allow this area to be open & available to BH pts where there will be enhanced security presence & monitoring by staff. **MOS: 90% Compliance** **Audit** dates & times that LSU is **not** open for **3 mths** to determine reason(s).	Pt. Safety: 7/11/13 7/31/13 & Yearly Pt. Safety: 9/13/13 8/31/13 Pt. Safety: 9/12/13; 10/10/13 & 11/14/13 12/18/13 Pt. Safety: 9/12/13; 10/10/13 & 1/2014 5/31/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13

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Z 160	Continued From page 2 patients at that time". The hospital failed to provide 1:1 constant observation in accordance with physician's orders and hospital policy. II. A review of the hospital policy entitled "Fall Precaution Policy, " states under "Policy Statement": "Every adult patient will be assessed for risk of falling on presentation to the Emergency Department and on admission. Reassessment will be completed at least daily; on transfer from one unit to another; following a fall or more frequently as determined by patient status." Under "Policy" it states: Item #3 "Under the direction of the Registered Nurse, the High Risk Interventions will be implemented for patients who are assessed to be a High Fall Risk based on a Schmid score -- 3 or greater. The following actions are required to initiate the program: (a) The Kardex will be stamped High Fall Risk; the numerical score result from the Schmid assessment and the date that assessment was completed will also be entered. (b) Patients who have been assessed to be at High Fall Risk will be further identified by placing a yellow bracelet and yellow slipper socks on the patient." Under "Post Fall Management," it states: Item #6. "Notify the attending physician and the	Z 160	7. Further Education will be provided w/ a mandatory quiz/competency for all RNs. **MOS: 100% Compliance** Completion of competency. **Patient Falls:** 1. Reviewed & revised Fall Prevention Protocol Policy # N-41- improve nsg comprehension of protocol. **-Policy approval** - Nsg Admin. 2. In EMR, add additional queries to safety assessment interventions. 3. In order to be scheduled for work post 6/01/13, all staff must document –Read & Sign revised policy (RNs, CNAs, & MHWs, including PD staff). **MOS: 100%** Required to Read & Sign which will be documented in API Tracking software. 4. Mandatory education for RNs, CNAs & MHWs on policy w/ emphasis on interventions associated w/ high v. low risk assess & documentation (during Skills Weeks) w/quiz. **MOS: 100% Compliance - Staff take quiz.** **Nsg Mgrs Audit: 5 records/wk/unit for 30 days-then mthly** (Documentation of interventions & did intervention fulfill intent) **until Compliance is 100%.** Then auditing will be reassessed. 5. Mandatory Education of Pharm staff on Schmid Fall Risk Assess & meds.	Fall 2013 4/26/13 4/26/13 5/30/13 Pt. Safety: 6/13/13 5/30/13 Pt. Safety: 6/13/13 Pt. Safety: 7/11/13, 9/12/13, 10/10/13 5/13/13

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Z 160	Continued From page 3 family of the fall. This notification can be completed during regular business hours providing the patient has not been injured." Item #7. "Reassess fall risk; review fall prevention interventions that were in place, it any, and modify plan of care as indicated." Item #8. "Document that the patient has fallen on the Kardex, in the SAFETY/RISK FACTOR SECTION and include date and time." 1. A review of the clinical record for patient ID #15 revealed a 76-year-old developmentally delayed patient who was transferred to the hospital from a group home after falling and sustaining a bruise to the right thigh and hip area. The patient was noted to have right sided back pain with swelling and a contusion. Record review indicates a Schmid Fall Risk assessment done in the ED (emergency department) scored the patient as 4 – indicating a "High" falls risk. There lacked evidence of a yellow bracelet or yellow socks placed on the patient in accordance with hospital policy. Additionally, while in the ED on 6/7/12 at approximately 11:30 PM, the patient was being assisted to a wheelchair by a nursing assistant, and suffered a fall which resulted in a fractured femur. Review of the patient's Kardex lacked evidence of the date and time of the fall, and the numerical score from the Schmid Assessment. There also lacked evidence of a falls reassessment after the fall, or any modification to the patient's plan of care. 2. A review of the clinical record for patient ID #32 reveals that the patient was brought to the hospital after tripping and falling at home. The	Z 160	**MOS: Competency Test.** 6. RPh will attend post fall huddles or rev meds w/in 24 hrs post fall. **-RPh interventions tracked & trended** in Meditech - ID if meds contributed to fall. The interventions will be used to determine if med patterns require education & revisions. 7. External expert on geriatric pharm & meds associated w/ falls will be brought in. Goal: to enhance the current Pharm Dept's efforts in conjunction with BH Unit practitioners & staff to provide evidence – based med guidelines for this pt population. **MOS:** Once the suggested guidelines have been created, utilization of guidelines will be initiated in effort to reduce variations. 8. Interactive educational sessions w/ nursing leader of a local skilled facility who has implemented a successful fall reduction plan- initially w/ Falls Comm, then to wider hospital audience. **MOS: Monitor** Fall Rates measured on all hosp units, including ED & outpt areas- Ongoing. **Target: 20% ↓ # of falls 12/2013.** 9. Focus Groups w/ ED, 3S & 4S staff to ID barriers to successfully ↓ # of falls & severity of injuries & address/correct/eliminate barriers as appropriate. **- Report findings** from Focus Groups along w/ resolution(s) or if unable to resolve, discuss next steps. Apply resolutions to other units as appropriate. **-Monitor** individual Unit Fall Rates- Ongoing.	Starting 5/14/13 Pt Safety: Monthly P&T: Ongoing Visit: 7/17/13 Pt. Safety: 9/12/13 for 6 Mths P&T: 9/2013 & Ongoing 6/22/13 - Falls Comm; & 12/30/13 - hosp audience Falls Comm. & Pt. Safety: Mthly 5/30/13 Falls Comm. & Pt. Safety: 6/13/13 Mthly

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Z 160	Continued From page 4 patient was complaining of right knee and hip pain as well as lower back pain. Although the Schmid Fall Risk assessment completed while in the ED revealed a score of 2 (low), the patient's fall risk was documented as "High," indicating that yellow socks and bracelet should be placed on the patient. The patient's ambulatory status was noted to be documented as "unable to ambulate". A "Standard Initial Care" ID Band was applied to the patient. There lacked evidence of a yellow band and yellow socks being placed on the patient. While in the ED the patient suffered a fall in the bathroom while being assisted to the toilet by a Registered Nurse. The patient complained of discomfort in the right lower leg. The patient was lifted from the floor back to a wheelchair and brought back to bed. Review of the ED nursing documentation reveals that the patient complained of right lower leg pain, with the anterior leg slightly red and warm to touch. Motrin was given for pain. The clinical record lacked evidence of a falls reassessment after the fall, with no new falls interventions and evidence that the family was notified of the fall. 3. A review of the clinical record for patient ID #3 revealed a 6/8/12 Schmid Fall Risk assessment which indicates a score of 2, a low risk for falls. At approximately 10:55 PM on 6/9/12 the patient fell while going to the bathroom, hitting her head. Review of the patient's Kardex reveals that the yellow bracelet and yellow slipper socks were not placed on the patient until 6/10/12 at 8:00 AM. The patient "Activity Assessment" following the fall on 6/10/12 at 8:00 AM indicates that the patient activity was "up ad lib." The Kardex also revealed a Schmid Fall Risk reassessment was not done until 6/10/12 at approximately 11:14 AM	Z 160	10. Develop plan & implement expansion of participation in post fall huddles & completion of fall huddle form. **MOS:** **Audit 100% of falls/mth** to determine if a post fall huddle is conducted & if post fall huddle form is completed. **Target 20% ↑/mth. Target: > 90% by 12/2013.** 11. Integrate info into post falls assess in Meditech & MERs. **MOS:** **Audit MERs falls reports weekly** - Insure Mgt completion of Registration/Discovery & Q/PI pgs of MERs. **Target: 20% ↑/mth until 95%.** **Note:** An additional recommendation is being made to require all Geriatric Psychiatry RNs to complete Geriatric Nursing classes offered through CharterCARE Continuum of Care, beginning 9/2013, with the goal of successful completion of Gerontological Nsg Certification Exam by said RNs by 12/2014	6/22/13 Falls Comm. & Pt. Safety: 7/11/13 & Mthly Pt. Safety: 7/11/13 & Mthly

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Z 160	Continued From page 5 and indicates a score of 3 (high), however the Fall Risk is noted to be "low". 4. A review of the clinical record for patient ID #29 revealed that the patient was brought to the ED on 6/4/12 after an unwitnessed fall at nursing home. Review of the Schmid Fall Risk completed in the ED reveals a score of 5, indicating that the patient is a "High" falls risk. The ED documentation also indicates the patient has had multiple falls. The record reveals that a "Standard Initial Care" ID bracelet was placed on the patient. There lacked evidence of a yellow bracelet and yellow socks being placed on the patient in accordance with hospital policy. Review of the patient's Kardex lacked evidence of numerical score of the Schmid Assessment, and also lacked a date and time the assessment was done. 5. A review of the clinical record of patient ID #30 reveals that the patient was brought to the ED from a nursing home for projectile vomiting. The Schmid Fall Risk completed in the ED indicates the patient is a "High" falls risk with a numerical score of 3. A "Standard Initial Care" ID Band was applied. There is no evidence of a yellow band and yellow socks being applied to the patient. When interviewed on 2/19/13 at approximately 11 AM, the Director of Nursing Services and the Clinical Manager of the Emergency Department reported that appropriate interventions for falls risk were not in this patient's chart, and that more interventions should have been put in place, and also indicated there was no reassessment after the patient fell. During an interview with the Risk Manager on 2/27/13 at approximately 11:00 AM, it was	Z 160		

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Z 160	Continued From page 6 reported that if a patient scores "High" on a Falls Risk Assessment, the falls risk should not be documented as "Low."	Z 160		
Z 370	PATIENT CARE SERVICES 19.6 PATIENT CARE MANAGEMENT 19.6 The hospital shall provide care and services to all patients in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to provide care in accordance with community standards, for 3 of 8 patients reviewed (ID #'s 26, 43 and 59), relative to assessment of bowel function on admission and ongoing throughout the hospital stay, and offering laxatives in accordance with standards of care. Findings are as follows: 1. A review of the clinical record for patient ID #26 revealed a 56-year-old admitted to the behavioral health unit on 8/28/12 from a long term care facility with SI (suicidal ideation) and depression. The patient has a past medical history of schizophrenia, seizure disorder, GERD (gastroesophageal reflux disease) and recurrent problems with constipation. A medical consult was performed on 8/31/12. The physical exam revealed a "distended abdomen" and "no normal bowel sounds." A review of the patient's bowel movement record reveals that from 8/29/12 – 9/2/12 (5 days) the patient did not move his bowels, and the PRN (as needed) order for Milk of Magnesia (MOM) was	Z 370	**Assess & Monitor Bowel Function:** 1. Set clear expectations & rev expectations of documentation re: completing bowel assess initially & every shift w/ all RNs of 2 Center. o Rev offer/use of PRN meds in relation indications from bowel assess. **MOS: 100%** of 2 Center RNs will attend mtg re: expectations of bowel assess (sign in sheets.) 2. Mgt will deal w/ findings from audits re: non- compliance by counseling individuals or review & education collectively as appropriate. **MOS: Audit 100% of charts/wk for 3 mth** re: assess of bowel functioning each shift & use of PRN laxatives, as needed **until 95 – 100% compliance; then audit 5 charts/mth - Ongoing.** 3. Add date of last bowel movement to shift - shift Hand Off Report Form. **MOS: 100% of 2 Center RNs** will be educated on revision to shift - shift report form. (sign in sheets.) **MOS: 100% Compliance. Audit observations of 5 Hand offs (on each shift) /mth until 100% compliance** and periodically for hardwiring the process.	5/31/13 Pt. Safety: 6/13/13 6/30/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13 5/13/13 Pt. Safety: 6/13/13 6/30/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13

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Z 370	Continued From page 7 not administered. On the evening of 9/2/12 the patient vomited and was noted to have a markedly distended abdomen. An abdominal film revealed "extensive small bowel and colonic detention with stool in the rectal vault". The impression revealed "the findings may be chronic but this raises the concern of distal colonic obstruction." 2. A review of the clinical record for patient ID #43 reveals an admission to the hospital on 2/4/13 for increased depression. The patient has a physician's order for MOM 30 ml (milliliters) daily, PRN (as needed) for constipation. The patient's bowel movement record revealed that the patient did not move bowels on 2/8 2/9 and 2/10. The MAR (Medication Administration Record) for this patient lacked evidence that the PRN MOM was administered. The patient was discharged on 2/11/13. 3. A review of the clinical record for patient ID #59 reveals an admission to the hospital on 2/13/13 for depression and SI (suicidal ideation). The patient had a physician's order for MOM 30 ml daily, PRN for constipation. The patient's bowel movement record reveals that the patient did not move bowels on 2/14, 2/15 and 2/16. Review of the MAR for this patient lacked evidence that the PRN MOM was administered as ordered. When interviewed on 2/12/13 at approximately 1:30 PM, the Clinical Nursing Manager for the unit, reported that the expectation is for the nurse to assess the patient for bowel sounds and to check what medications are ordered for the patient. She indicated that the MOM should have been administered after the second or third day if no bowel movement.	Z 370		

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Z 375	PATIENT CARE SERVICES 19.7 PATIENT CARE MANAGEMENT 19.7 Medical Restraints: In acute medical and pre/post-surgical care, a patient shall be free from physical and chemical restraint that is not medically necessary. A restraint shall only be used if needed to improve the patient's well-being and only if less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. Behavioral Restraints: A patient shall be free from seclusion or restraint imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint employed for behavior management shall only be used in emergency situations if needed to ensure the patient's or other's physical safety and less restrictive interventions have been determined to be ineffective. 19.7.1 Restraints/seclusion use shall be prescribed in writing and signed by a physician or other licensed practitioner acting within his/her scope of practice and permitted by the hospital to order restraints/seclusion. The type and duration of restraints/seclusion shall be specified. Standing or "on an as needed basis" (i.e., PRN) orders shall not be permitted. 19.7.2 Restraints/seclusion, if used, shall be addressed in the written treatment plan for the patient. 19.7.3 Restraints/seclusion use shall be based on an assessment of the patient, implemented in the least restrictive manner possible, implemented in accordance with safe and appropriate restraining techniques, and discontinued at the earliest possible time. 19.7.4 The condition of a restrained/secluded patient shall be continually assessed, monitored, and revaluated.	Z 375	**Use of a Chemical Restraint in The ED:** 1. All ED staff including RNs, LIPs & MDs will Read & Sign Restraint Seclusion & Restraint Alternatives Policy #04.953.282. **MOS: 100% Compliance** (sign in sheets.) 2. Develop education re: definition of chem restraint; ways to approach pt inclusive of MH Laws (vol v. invol admin of med); providing guideline scripts for staff; what to do when a pt lacks capacity; clarifying use of a chem restraint in ED; & appropriate documentation of a chem restraint. This event will be presented as a case study. Points to consider: use of chem. restraint; Pt Rts; & alternative methods. 3. All ED RNs, LIPs & MDs will attend & participate in above education. **MOS: 100% Compliance** (sign in sheets.) 4. Develop & present 4 case studies (ED scenarios) at clinical mtgs w/ all RN staff where staff actively present scenarios & participate in discussion of ways to handle additional situations. **MOS: 100% Compliance** (sign in sheets.) 5. Pharm will conduct a 14 day retrospective review of Haldol use in ED to obtain baseline of Haldol utilization & provide data to ED Mgr, who w/ assistance of Med Dir of ED, will review the data to insure there are no trends involving Haldol use for chem restraint. 6. Current restraint audit tool will now include appropriate use of chem restraints as well as	5/31/13 Pt. Safety: 6/13/13 5/31/13 6/30/13 Pt. Safety: 7/11/13 7/31/13 Pt. Safety: 9/12/13 5/6/13 6/30/13 6/30/13

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Z 375	Continued From page 9 This Requirement is not met as evidenced by: Based on review of the clinical record and staff interview it has been determined that the hospital failed to ensure that less restrictive interventions and/or alternatives had been employed and ineffective prior to chemically restraining 1 of 6 patients with a change in mental status. (ID#6) Findings are as follows: A review of the clinical record for patient ID #6 reveals a transport to the hospital on 9/9/12 from an Assisted Living Facility (ALF) for a change in mental status. Review of the COC (Continuity of Care) form from the ALF revealed "Patient change in mental status. Acting out upon staff and other residents even after PRN (as needed) Ativan given". The patient has a past medical history of HTN (hypertension), Bipolar disorder, Parkinsonism and Schizophrenia. The patient was placed on constant observation in the ED, and was evaluated by a behavioral health center. The assessment indicated that an inpatient admission would not be appropriate as the "...pt does not appear to be exhibiting extreme behaviors that are out of norm. Pt does not meet inpatient criteria at this time." The patient remained in the ED until his discharge on 9/10/12. The ED record reveals that the patient's behavior during his observation period was "alert and oriented and often times sleeping". When awake, the patient was noted to have appropriate behavior and was "relaxed and cooperative". On 9/10/12 at approximately 1920 (7:20 PM) the patient was noted to be yelling and swearing regarding not leaving the hospital. The patient requested to stay in the hospital "because he	Z 375	phys restraints. **MOS:** **Audit 100% of restraints used** (including chem restraint use) **in ED/mth for a min of 3 mths until compliance is 100%.** Then determination to be made for future monitoring.	Pt. Safety: 9/12/13

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Z 375	Continued From page 10 likes it better here". Record documentation revealed "MD in to talk with Pt. and was yelled at. MD ordered 10mg Haldol IM (intramuscular) and given." The patient was noted to continue to yell and was subsequently administered 2 mg of Ativan and 50 mg of Dipenhydramine IM as ordered. The Haldol was administered at 7 PM and the Ativan and Dipenhydramine were both administered at 7:19 PM. The patient left the facility at 7:40 PM. When interviewed on 1/25/13 at approximately 12:30 PM, the nurse who administered the medications indicated the patient was fine during the shift. It was when the patient was told that he/she would be returning to the ALF that he/she became verbal and argumentative, but not physically aggressive. The nurse revealed that the patient calmed down after administration of all above medications, and remained non-combative and cooperative while waiting for the ambulance. Interview on 1/29/13 at 1:00 PM with the PA (Physician's Assistant) who ordered the medication, revealed that the patient was calm and non-combative, and receiving his regularly scheduled medications. The patient reportedly only became agitated when EMS (Emergency Medical Services) arrived, at which point the patient began yelling and escalated and was unable to calm down; he was medicated and did calm down after about 10 minutes. When asked if any of the patient's discharge medications were changed, the PA stated "no, all of the patient's medications he was receiving before coming to the ED remained the same". When interviewed on 1/31/13 at 9:00 AM, the licensed clinical social worker from the behavioral health center who evaluated the patient indicated	Z 375		

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Z 375	Continued From page 11 that the patient's behavior was fine, he was cooperative, non combative and not physically aggressive. It was based on this evaluation that the patient was deemed appropriate to discharge back to the ALF. There was no evidence that the patient had been physically aggressive or combative during his stay in the ED. There was no evidence that alternative or less restrictive methods were tried prior to administering the chemical restraint.	Z 375		
10	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on review of hospital occurrence reports submitted to the Department of Health, and staff interview, it was determined that the hospital failed to report to the licensing agency, within 72 hours, reportable incidents/event for 5 of 18 relevant sample patients (ID #'s 52, 55, 61, 62 and 63) Findings are as follows: 1. A reportable incident occurring for patient ID #52 on 12/4/12 was not reported to the licensing agency until 12/15/12. 2. A reportable incident occurring for patient ID #55 on 11/16/12 was not reported to the licensing	Z 940	**Late Reporting of Incidents (Crowley Bill) to DOH:** 1. Review & revise Incident Reporting Policy #03-957-03. 2. Review & revise Hosp Incident/Events Reporting to RI DOH Policy #01-950-83. 3. Develop & present Education at Nsg Leadership & Nsg Supervisors re: revisions to policies; types of events to be reported & importance of timely reporting in MERs by end of shift; & type of info initially needed to include in MERs. RM will provide Talking Points for Mgrs re: Types of events/incidents reportable w/in 24-72 hrs of event; Mgr/Dir/ Supervisor to page RM for all incidents resulting in major harm/death/a sentinel events and call or voice msg RM for all events that result in moderate harm; & all depts w/ paper MR to provide copies of applicable sections of MR to RM via fax w/in 24 hrs of a reportable incident. **MOS: 100 % Compliance** - Attendance (sign in sheets.)	5/31/13 5/31/13 6/30/13 Pt. Safety: 7/11/13

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Z 940	Continued From page 12 agency until 11/30/12. 3. A reportable incident occurring for patient ID #61 on 8/7/12 was not reported to the licensing agency until 9/25/12. 4. A reportable event occurring for patient ID #62 on 9/26/12 was not reported to the licensing agency until 10/3/12. Continued From page 12 5. A reportable incident occurring for patient ID #63 on 9/14/12 was not reported to the licensing agency until 10/3/12. During an interview on 3/5/13 at approximately 1:30 PM with the Risk Manager, she was unable to provide evidence that the above incidents/event were reported to the licensing agency within 72 hours.	Z 940	4. Nsg Mgrs/Dir hold staff mtgs w/RNs to rev presentation presented at Leadership, Read & Sign policies & have all RNs complete a PP competency & quiz on types of incidents that should be reported in MERs including but not limited to "Crowley Bill" DOH reportable incidents & timely reporting in MERs during shift in which incident occurred. **MOS: 100% Compliance of Nsg units** – hold meeting w/ RNs (minutes from mtgs.) **MOS: 100% of all RNs** will Read & Sign policies which will be documented in API tracking software. **MOS: 100% Compliance**- all RNs complete PP & quiz, which will be documented in API tracking software. 5. RM to provide Education to specific areas w/ high non-compliance identified by baseline audits. Areas of non-compliance will be identified by baseline audit of 100% of DOH reports - 4th Q 2012 & 1st Q 2013. 6. Claims Coord/ MERs Adm will increase hrs from 20 to 40 hr/week in RM Dept - taking on responsibilities that do not require clinical judgment. 7. RM Dept will only include essential elements in initial report/notification to DOH. **MOS: 95% - 100% Compliance**-timely reporting to DOH. **Audit: 100% of DOH** reports/mth for untimeliness of reporting & reasons. Develop action plans accordingly.	7/31/13 Pt. Safety: 9/12/13 Pt. Safety: 9/12/13 Audits: 7/11/13 Pt. Safety: 7/11/13 5/1/13 Ongoing Pt. Safety: 7/11/13 & Mthly until 95-100%

Department of Health
Three Capitol Hill
Providence, RI 02908-5097
TTY: 711
www.health.ri.gov

September 24, 2013

Mr. Kenneth Belcher, President/CEO
Roger Williams Medical Center
825 Chalkstone Avenue
Providence, RI 02908

Dear Mr. Belcher:

This office has received the Plan of Correction for the deficiencies cited as a result of our review completed on August 20, 2013. The provisions and time frames for your corrective action is determined to be acceptable.

Please note that a member of the Facilities Regulation staff will make an unannounced site visit to the hospital to ensure compliance has been achieved.

If you have any questions, please contact Madeline Vincent at 401-222-2566.

Sincerely,

Raymond Rusin, Chief
Facilities Regulation
(401) 222-2566

MV

CharterCARE
HEALTH PARTNERS

WWW.CHARTERCARE.ORG

September 13, 2013

Raymond Rusin
Chief Facilities Regulation
Department of Health
Three Capitol Hill
Providence, RI 02908-5097

RE: Investigation completed on August 20, 2013

Dear Mr. Rusin:

This is in response to your correspondence to me dated August 29, 2013 in regards to our hospital not being in compliance with the Rules and Regulations for Licensing of Hospitals and corresponding citations noted on the enclosed Statement of Deficiencies (State Form).

Please see our plan of correction on the State Form (Provider's Plan of Correction) with the date of completion, signed and dated as per your request.

Should you have any questions please feel free to call myself at 456-2025 or Joyce Hackley, Director, Risk Management at 456-2405.

Sincerely,

Kenneth H. Belcher
President/CEO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING _____ B. WING _____	8/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEBYFULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIFICENCY	(X5) COMPLETION DATE
Z 115	ORGANIZATION & MANAGEMENT 9.5 Quality Improvement	Z 115	**Plan:** All reportable incidents under 23-17-40 Hospital Event Reporting will be reported to the Department of Health (DOH) within seventy-two (72) hours. All incidents will be presented to the appropriate committee within the hospital and have a peer review performed, with notification back to the DOH within 6 months from the date of the initial report. **Do:** **Patient ID #33** related to an incident occurring on 12/5/2012 was brought to the appropriate peer review committee on August 29, 2013. Once the peer review is received it will be presented to the peer review committee and the DOH will be notified of the outcome of the internal review as soon as the information is made available as is our usual practice. **Check:** Committee minutes will reflect the discussion by the members of the peer review and the outcome. Follow-up report will be sent to the DOH via Health's secured web file repository. Confirmation of file will be attached to hospital copy of the Follow-up report that was sent. A log will be kept in Risk Management to track the date of the incident, date sent to the DOH, date incident brought to the peer review committee and date closed.	10/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9/13/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING _____ B. WING _____	8/20/13

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

Z 940	PATIENT CARE SERVICES 34.8 Reportable Incidents	Z 940	**Plan:** All reportable incidents under 23-17-40 Hospital Event Reporting will be reported to the Department of Health (DOH) within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. **Do :** **Patient ID #'s 15, 34, 35, 36 & 37** and all other incidents that the hospital decides to report to our malpractice insurance carrier will be reported to the DOH within 72 hours of us reporting the incident to our malpractice insurer unless the incident met one of the reporting requirements other than "reported to the malpractice insurance carrier". We will explain in the brief description of the Hospital Incident reporting form the reason for the difference in the date of the report and the incident date. Our records reveal that **ID#37** has a date of incident of 10/4/12; decision made to report to our malpractice insurer as a precautionary measure on 10/24/12 and reported to the DOH on 10/24/12. Hospital Incident reporting form asked to be resent to the DOH on 11/2/12. See attachment #1. **Check:** Documentation of the reason that the date of the incident and the reported date are greater than 72 hours within the brief description of the Hospital Incident reporting form. A log will be kept in Risk Management to track the date incident was reported to the malpractice insurer and the date the incident was reported to the DOH when the date reported to the DOH is greater than 72 hours from the date of the incident.	9/26/13

CEO 7/13/13

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

Z 950	PATIENT CARE SERVICES 34.10 Reportable Incidents	Z950	**Plan:** The hospital shall notify the licensing agency of the outcome of the internal review as soon as this information is available but no later than six (6) months after the initial report. **Do:** A "Follow-up Report" will be submitted to the licensing agency within the six (6) month time period after the submission of the initial report via Health's secured web file repository. **Check:** Monthly follow-up calls and written correspondence to all peer reviewers if the review has not been received to date. Documentation of actions will be kept with all individual incident minutes. Untimely return of the peer review by the requested reviewer will be reported to the Quality Department every three months and will be tied to the OPPE process which is tied to the reappointment process.	9/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9/13/13

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Department of Health
Three Capitol Hill
Providence, RI 02908-5097
TTY: 711
www.health.ri.gov

August 29, 2013

Mr. Kenneth Belcher, Administrator
Roger Williams Medical Center
825 Chalkstone Avenue
Providence, RI 02908

Re: Investigation completed on August 20, 2013

Dear Mr Belcher:

This letter is a follow-up to an investigation completed at Roger Williams Medical Center on August 20, 2013. This visit included, but was not limited to, investigation of complaints regarding allegations of non-compliance.

Please note the following results for the related Intake ID number (see roster):

RI00027232 - Unsubstantiated
RI00027802 - Unsubstantiated
RI00028701 - Unsubstantiated
RI00029009 - Unsubstantiated
RI00029236 - Unsubstantiated
RI00029502 - Unsubstantiated
RI00029734 - Unsubstantiated
RI00029790 - Unsubstantiated
RI00030644 - Unsubstantiated
RI00030846 - Unsubstantiated
RI00030991 - Unsubstantiated
RI00031101 - Unsubstantiated
RI00031152 - Substantiated, no deficiency
RI00031646 - Unsubstantiated
RI00032154 - Unsubstantiated
RI00033013 - Unsubstantiated
RI00033520 - Unsubstantiated
RI00033622 - Unsubstantiated
RI00033744 - Substantiated, no deficiency
RI00033825 - Unsubstantiated
RI00033936 - Unsubstantiated
RI00034203 - Unsubstantiated
RI00035588 - Unsubstantiated
RI00035803 - Unsubstantiated

This survey found that your facility was not in compliance with the Rules and Regulations for Licensing of Hospitals and citations are noted on the enclosed Statement of Deficiencies (State Form). A plan of correction is required and must be submitted to this office by September 13, 2013. Please enter, in the right hand column of the State Form (Provider's Plan of Correction), your response to each citation with a date of completion (X5 complete date), sign (X6 Date) and return to this office by September 13, 2013.

Your Plan of Correction must contain the following:

- What corrective actions will be accomplished for those patients/situations found to have been affected by the deficient practice;

- How you will identify other patients/situations having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place of what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

If you have any questions regarding this issue, please call Deborah Massaniso RN SNCE at 401-222-4529..

Thank you for the courtesy extended to our survey staff during this investigation.

Sincerely,

Raymond Rusin, Chief
Facilities Regulation

DM

RI Department of Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 0	INITIAL COMMENTS An 'Other' State licensure survey and a State complaint investigation survey (67DO11, 8/30/13) were conducted at this facility. Deficiencies were cited relative to the 'Other' State licensure survey.	Z 0		
Z 115	ORGANIZATION & MANAGEMENT 9.5 Quality Improvement 9.5 All medical and surgical services performed in the hospital shall be evaluated for appropriateness in diagnosis and treatment. The evaluation shall include peer review of individual cases. The hospital shall maintain records of peer reviews, documenting the case(s) reviewed, focus of each review, findings, conclusions, any actions taken, and any follow-up on actions taken. This Requirement is not met as evidenced by: Based on document review and staff interview, it was determined the hospital failed to ensure that a peer review was performed to evaluate for appropriateness in diagnosis and treatment for 1 of 4 relevant sample patients (ID #33). Findings are as follows: The hospital was unable to provide evidence of a peer review for patient ID #33 related to an incident occurring on 12/5/2012. Interview on 8/19/2013 at approximately 12 PM with the Director of Risk Management, revealed a peer review had not been obtained.	Z 115		
Z 940	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or	Z 940		

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING: _____ B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z 940	Continued From page 1 after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on review of hospital occurrence reports submitted to the Department of Health and staff interview, it was determined that the hospital failed to report to the licensing agency, within 72 hours, reportable incidents for 5 of 7 relevant sample patients (ID #s 15, 34, 35, 36 and 37). Findings are as follow: 1. A reportable incident occurring for patient ID # 15 on 9/28/2012 was not reported to the licensing agency until 10/30/2012. 2. A reportable incident occurring for patient ID # 34 on 11/2/2012 was not reported until 11/16/2012. 3. A reportable incident occurring for patient ID # 35 on 9/11/2012 was not reported until 9/21/2012. 4. A reportable incident occurring for patient ID # 36 on 9/19/2012 was not reported until 10/10/2012. 5. A reportable incident occurring for patient ID # 37 on 10/4/2012 was not reported until 10/24/2012. During an interview with the Director of Risk Management on 8/19/2013 at approximately 12 PM, she was unable to provide evidence that the	Z 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 940	Continued From page 2 above incidents were reported to the licensing agency within the required 72 hours.	Z 940		
Z 950	PATIENT CARE SERVICES 34.10 Reportable Incidents 34.10 The hospital shall ensure an appropriate committee or multidisciplinary group conducts peer review for all reportable incidents. The hospital shall notify the licensing agency of the outcome of the internal review as soon as this information is available but in no case later than six (6) months after the initial report and if the findings determine that the incident was within the normal range of outcomes, no further action shall be required. This Requirement is not met as evidenced by: Based on review of hospital reportable incidents and staff interview, it was determined that the hospital failed to notify the licensing agency, no later than 6 months after the initial report, of the outcome of the peer review for 1 of 7 relevant sample patients (ID #6) Findings are as follows: A review of the hospital's incident reports filed with the Department of Health revealed that the hospital reported the incident, but failed to submit to the licensing agency the " Follow-up Report" within the required time frame of 6 months. A " Follow-up Report " for an incident occurring on 1/4/2012, was not made available to the licensing agency until 8/12/2012. During an interview on 8/19/2013 at approximately 12 PM, the Director of Risk Management was unable to provide evidence that	Z 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 950	Continued From page 3 a "Follow-up Report" had been submitted to the licensing agency within the 6 month time frame as required.	Z 950		

EXHIBIT Q48-1

CHARITY AND COLLECTION POLICIES (WATERBURY HOSPITAL)

POLICY: CHARITY CARE		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 3
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 12/5/97 (From PAFS manual)
LAST REVIEWED: 11/11	LAST REVISED: 8/13	RETIRED:

SCOPE: Determination of when charity care is appropriate.
PURPOSE: To make provisions for situations in which charity care is appropriate based on aggregate balance and Encounter review.

POLICY: It is the policy of Waterbury Hospital to appropriately offer charity care in situations where the responsible party for the balance due does not have the financial resources necessary to satisfy their obligation within a reasonable period of time.

1. All patients who request consideration for charity care will be required to apply for public assistance in addition to completing a charity care application unless identified as ineligible by a qualified case worker.

2. In order to be considered for charity care, full financial disclosure is required including:
    a. All sources of income available at the time of application;
    b. Assets excluding;
        i. Primary Residence;
        ii. Vehicles required for commuting to or facilitating employment;
        iii. Retirement Accounts.

3. Responsible parties with assets of $7,500 or less ($15,000 for a couple) will receive the following discounts based on their annual household income and the published federal poverty guidelines in effect at the date of application:

Income as a % of FPL	Discount
<200%	100%
<= 225%	60%
<= 275%	40%
<= 300%	20%
<= 400%	10%

4. Charity care discounts are to be applied after the 50% uninsured discount from charges.

5. Documentation required to validate declarations made on the charity care application shall include:
    a. A credit report;
    b. Most recent 1040 tax return;
    c. Copies of all bank statements to include but not limited to:
        i. Checking accounts;
        ii. Savings accounts;
        iii. Investment accounts;
        iv. Certificates of deposit
    d. Proof of income for the immediate 12 months preceding the application date.
    e. Public assistance determination.

PROCEDURE:

1. The availability of charity care will be disclosed on all dunning notices issued prior to bad debt assignment.

2. Patients who indicate they are unable to pay for services rendered will be offered charity care;

3. Financial Counselors shall evaluate each applicant's eligibility.

4. Accounts determined to be eligible for charity care discounts shall require the following authorization based on amount to be adjusted:
   a. PAFS Manager < $5,000
   b. PAFS Director $5,000 or more
   c. Chief Financial Officer $10,000 or more

5. Patients shall be issued a determination letter within 30 days of receipt of a completed charity care application.

6. Patients who do not apply for or do not qualify for charity care will be expected to pay the balance due. For uninsured patients, this will be equivalent to 50% of charges. Insured patients will be expected to pay any deductible or co-payment due in addition to 50% of non-covered charges.

7. Patient who do not enter into a payment plan or pay satisfy the balance due will be placed with a collection agency for further collection efforts. The collection agency may report the balance due to credit reporting bureaus and/or initiate legal action to resolve the debt.

Approved: _____ 8/8/13
Mark Sammartano
Director, PAFS
Date

Approved: _____ 2/12/2014
CFO/VP Finance
Date

POLICY: POINT OF SERVICE COLLECTIONS		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PAFS		ORIGINATED: 10/01/2015
LAST REVIEWED:	LAST REVISED:	RETIRED:

SCOPE: This policy covers all elective and scheduled services.
PURPOSE: The purpose of this policy is to establish processes and procedures that will enable the facility to manage discretionary bad debt.

POLICY:

1. It is the policy of Greater Waterbury Hospital to treat all patients who require urgent care regardless of their ability to pay for services.

2. Patients who present for urgent care shall receive a medical screening examination and be stabilized prior to any discussion regarding payment for services.

3. Patients who wish to schedule elective services and have a history of bad debt, are likely to be responsible for 50% or more of the estimated cost of care, or will have an out-of-pocket balance due of $500 or more will be expected to establish satisfactory payment terms prior to being scheduled for services.

4. The hospital will continue to offer free care and discounted care to eligible patients based on the Federal Poverty Limits published annually (see Administrative Policy "Charity Care").

PROCEDURE:

Upon receiving a scheduling request, the scheduler shall evaluate the patient's estimated out-of-pocket balance, any current balances due, as well as bad debt balances due to determine if the patient will be required to enter into a satisfactory payment plan.

1. If a co-pay/deductible is required, the verification staff will require the following payment options:

   - If the patient's co-pay/deductible is over $500.00, the patient will minimally be responsible to pay 50% of the co-pay/deductible amount prior to the scheduled service date. The remaining patient balance may be placed into a payment arrangement of four to six months.

   - If the patient's co-pay/deductible is under $500.00, the patient will minimally be responsible to pay 50% of the co-pay/deductible amount. The remaining patient balance may be placed into a payment arrangement of up to three months.

2. If the patient has had previous bad debt accounts within the past two years, the patient will be classified as a credit risk and will be required to pay 100% of the co-pay/deductible prior to the scheduled admission/procedure date.

3. If any required payment is not satisfied, the patient will be informed that the physician's office will be contacted to determine whether the procedure can be rescheduled or cancelled. Patients will be notified within one day if the physician's office does cancel or reschedule the admission/procedure.

4. If the physician's office declines to cancel because of medical necessity, the admission/procedure will proceed as scheduled. All cases identified with this occurring will be subject for review by the hospital's utilization management staff.

5. Patients shall not be eligible for prompt pay discounts if they have prior outstanding balances or are making a partial payment for estimated balances due.

POINT OF SERVICE COLLECTIONS

Approved: _____ _____
Mark Sammartano Date
Director, PAFS

Approved: _____ _____
James Moylan Date
CFO/VP Finance

POLICY: UNINSURED PATIENT DISCOUNT		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 4/13
LAST REVIEWED: 4/15	LAST REVISED:	RETIRED:

SCOPE: All PFS and Patient Access staff.
PURPOSE: To align balances due from uninsured patients with payments received from insurance carriers.

POLICY:

1. Uninsured patients shall be entitled to a discount of 50% of charges.
2. This discount shall be posted to the patient's account at the time a final bill is generated.
3. Any additional discounts such as prompt pay or charity care shall be calculated after the uninsured discount is applied.
4. Accounts forwarded to collections shall be placed net of the uninsured discount.

PROCEDURES:

1. Posting of the uninsured discount shall be automated through the HIS in place at the time the bill is generated.
2. In the event insurance coverage is identified after the uninsured adjustment has been posted, the adjustment shall be reversed and any applicable contractual allowance posted as per standing protocol for the specific payer.

UNINSURED PATIENT DISCOUNT

Approved: _____ _____
Mark Sammartano Date
Director, PAFS

Approved: _____ _____
Edward Romero Date
CFO/VP Finance

POLICY: PROMPT PAY DISCOUNT		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 4/13
LAST REVIEWED:	LAST REVISED:	RETIRED:

SCOPE: Billing practices for uninsured patients.
PURPOSE: To establish an equitable method of billing uninsured patients considering insurance reimbursement practices.

POLICY:

1. In order to reduce the cost of collections and increase the availability of working capital, a 25% discount will be offered to patients who pay the estimated balance due on or before the date of service.

2. Uninsured patients shall receive this discount in addition to any uninsured discounts effective at the time of service.

3. Insured patients shall receive this discount if payment is received at time of service based on an estimate of their out-of-pocket expenses. This discount shall be extended to any additional balances due in the event the estimated balance is less than the actual amount due after the claim has been paid by the insurance carrier provided the remaining balance is paid within 30 days of the first patient bill.

PROCEDURES

1. Non-urgent patients shall be notified of their estimated balance due prior to receiving services to include open AR and unresolved bad debt balances.

2. Urgent patients shall be notified of their estimated balance due, including unresolved active AR and bad debt, after their medical condition has been stabilized.

3. A 25% discount shall be extended to any portion of the debt paid by the patient upon notification of the total estimated balances due to the hospital.

4. Upon collection of payment, a receipt for the amount tendered will be issued with the discount clearly documented.

5. The white copy of the receipt will be given to the patient for their records.

6. The pink copy will be forwarded to the cashier with the funds for posting both payment and the discount.

7. The yellow copy will be retained in the receipt book at the department.

8. Upon depletion of a receipt, it will be the department's responsibility to archive these books in accordance with existing document retention policies.

Approved: _____ _____
Mark Sammartano Date
Director, PAFS

Approved: _____ _____
Date
CFO/VP Finance

EXHIBIT Q50-1

OHCA FINANCIAL STATISTICS REPORT (GWHN)

Waterbury Hospital Only

	Month of Apr-14	Y-T-D 04/30/14	Month of Apr-15	Y-T-D 04/30/15	Month of May-14	Y-T-D 05/31/14	Month of May-15	Y-T-D 05/31/15	Month of Jun-14	Y-T-D 06/30/14	Month of Jun-15	Y-T-D 06/30/15
A. Operating Performance												
Operating Margin	5.60%	1.61%	-19.90%	0.10%	0.43%	1.46%	-10.73%	-1.14%	-11.48%	0.08%	-1.87%	-8.19%
Non-Operating Margin	6.35%	3.31%	-18.84%	1.40%	1.28%	3.05%	-9.85%	0.12%	-10.61%	1.59%	-0.65%	-7.25%
Total Margin	6.45%	3.33%	-18.87%	1.39%	1.34%	3.08%	-9.26%	0.18%	-10.59%	1.62%	-0.60%	-7.28%
Bad Debt as % Gross Revenue	-1.93%	0.19%	-1.66%	0.25%	4.63%	0.77%	0.51%	0.28%	-2.12%	0.45%	0.27%	0.14%
B. Liquidity												
Current Ratio	1.98	1.98	1.91	1.91	2.14	2.14	1.78	1.78	1.76	1.76	1.57	1.57
Days Cash on Hand	55.26	55.26	47.96	47.96	47.98	47.98	48.92	48.92	56.02	56.02	49.69	49.69
Days in Net Accounts Receivables	45.90	45.90	53.87	53.87	47.39	47.39	56.93	56.93	52.00	52.00	64.03	64.03
Average Payment Period	42.43	42.43	40.44	40.44	37.41	37.41	44.23	44.23	45.27	45.27	48.01	48.01
C. Leverage and Capital Structure												
Long-term Debt to Equity	1.4726	1.4726	3.5670	3.5670	1.5234	1.5234	5.3177	5.3177	1.7923	1.7923	10.2958	10.2958
Long-term Debt to Capitalization	0.5956	0.5956	0.7810	0.7810	0.6037	0.6037	0.8417	0.8417	0.6419	0.6419	0.9115	0.9115
Unrestricted Cash to Debt	0.7518	0.7518	0.4701	0.4701	0.5595	0.5595	0.4864	0.4864	0.6347	0.6347	0.5132	0.5132
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	3.07	3.07	-0.48	-0.48	2.38	2.38	-1.44	-1.44	1.73	1.73	-1.30	-1.30
Equity Financing Ratio	4.19	4.19	11.00	11.00	4.16	4.16	16.95	16.95	5.37	5.37	34.37	34.37
D. Additional Statistics												
Income from Operations	1,762,320	6,832,700	(2,229,359)	4,498,875	762,995	7,595,695	(1,076,954)	3,421,921	(1,287,050)	6,308,645	2,713,577	(708,344)
Revenue Over/(Under) Expense	1,244,562	4,206,710	(2,707,054)	1,720,164	242,785	4,449,495	(1,472,455)	247,709	(1,825,125)	2,624,370	(935,379)	(1,183,088)
EBITDA	1,762,320	6,832,700	(2,229,359)	4,498,875	762,995	7,595,695	(1,076,954)	3,421,921	(1,287,050)	6,308,645	2,713,577	(708,344)
Patient Cash Collected	19,133,328	122,616,001	16,344,751	116,992,804	16,933,631	139,549,632	15,045,288	132,038,092	16,713,514	156,263,146	148,192,895	16,154,803
Cash and Cash Equivalents	20,455,135	20,455,135	12,227,335	12,227,335	15,179,232	15,179,232	12,575,558	12,575,558	17,172,188	17,172,188	13,229,814	22,002,562
Net Working Capital	27,070,632	27,070,632	24,721,814	24,721,814	27,175,476	27,175,476	22,746,727	22,746,727	23,123,042	23,123,042	18,291,590	18,291,590
Unrestricted Assets	17,899,467	17,899,467	7,044,328	7,044,328	17,257,757	17,257,757	4,697,030	4,697,030	14,629,775	14,629,775	2,418,973	2,418,973
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Waterbury Hospital Only

	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15
A. Operating Performance								
Operating Margin	-1.23%	-0.06%	-18.30%	-3.40%	-3.87%	-0.40%	-10.44%	-4.01%
Non-Operating Margin	-0.22%	1.40%	-17.27%	-2.20%	-2.41%	1.06%	-9.51%	-2.83%
Total Margin	-0.19%	1.43%	-17.34%	-2.16%	-2.36%	1.10%	-9.58%	-2.80%
Bad Debt as % Gross Revenue	-3.18%	0.09%	1.03%	0.35%	0.77%	0.15%	0.86%	0.39%
B. Liquidity								
Current Ratio	1.73	1.73	1.53	1.53	1.91	1.91	1.56	1.56
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69
C. Leverage and Capital Structure								
Long-term Debt to Equity	1.9083	1.9083	-23.7088	-23.7088	2.0337	2.0337	-6.2679	-6.2679
Long-term Debt to Capitalization	0.6562	0.6562	1.0440	1.0440	0.6704	0.6704	1.1898	1.1898
Unrestricted Cash to Debt	0.7582	0.7582	0.3218	0.3218	0.6156	0.6156	0.2694	0.2694
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31
Equity Financing Ratio	5.81	5.81	-76.40	-76.40	5.95	5.95	-20.33	-20.33
D. Additional Statistics								
Income from Operations	447,817	6,756,462	(2,301,275)	412,302	4,351	6,760,813	(1,055,933)	(643,631)
Revenue Over/(Under) Expense	(35,827)	2,588,543	(2,772,128)	(3,707,507)	(416,695)	2,171,848	(1,547,662)	(5,255,169)
EBITDA	447,817	6,756,462	(2,301,275)	412,302	4,351	6,760,813	(1,055,933)	(643,631)
Patient Cash Collected	16,953,790	173,216,936	17,588,030	165,780,926	16,391,215	189,608,151	16,367,950	182,148,876
Cash and Cash Equivalents	20,457,074	20,457,074	3,010,785	8,257,373	16,563,273	16,563,273	2,978,798	6,880,235
Net Working Capital	22,842,265	22,842,265	15,242,354	15,242,354	25,043,856	25,043,856	16,052,250	16,052,250
Unrestricted Assets	13,704,068	13,704,068	(1,045,742)	(1,045,742)	12,825,022	12,825,022	(3,936,749)	(3,936,749)
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Total GWHN

	Month of Apr-14	Y-T-D 04/30/14	Month of Apr-15	Y-T-D 04/30/15	Month of May-14	Y-T-D 05/31/14	Month of May-15	Y-T-D 05/31/15	Month of Jun-14	Y-T-D 06/30/14	Month of Jun-15	Y-T-D 06/30/15
A. Operating Performance												
Operating Margin	3.34%	-1.72%	-16.32%	-3.57%	-2.55%	-1.77%	-13.33%	-4.69%	-11.69%	-2.85%	-10.80%	-5.33%
Non-Operating Margin	4.03%	-0.30%	-15.54%	-2.53%	-1.83%	-0.44%	-12.63%	-3.68%	-10.94%	-1.58%	-10.06%	-4.35%
Total Margin	4.24%	-0.13%	-17.66%	-2.72%	-0.92%	-0.17%	-12.14%	-3.80%	-10.70%	-1.32%	-11.09%	-4.57%
Bad Debt as % Gross Revenue	-1.67%	0.26%	-1.43%	0.31%	4.33%	0.79%	0.53%	0.33%	-1.93%	0.49%	0.21%	0.32%
B. Liquidity												
Current Ratio	1.91	1.91	1.74	1.74	1.99	1.99	1.62	1.62	1.69	1.69	1.45	1.45
Days Cash on Hand	55.26	55.26	47.96	47.96	47.98	47.98	48.92	48.92	56.02	56.02	49.69	49.69
Days in Net Accounts Receivables	45.90	45.90	53.87	53.87	47.39	47.39	56.93	56.93	52.00	52.00	64.03	64.03
Average Payment Period	42.43	42.43	40.44	40.44	37.41	37.41	44.23	44.23	45.27	45.27	48.01	48.01
C. Leverage and Capital Structure												
Long-term Debt to Equity	0.6687	0.6687	0.9854	0.9854	0.6754	0.6754	1.0831	1.0831	0.7215	0.7215	1.2112	1.2112
Long-term Debt to Capitalization	0.4007	0.4007	0.4963	0.4963	0.4031	0.4031	0.5200	0.5200	0.4191	0.4191	0.5478	0.5478
Unrestricted Cash to Debt	1.0331	1.0331	0.7666	0.7666	0.8446	0.8446	0.7939	0.7939	0.9274	0.9274	0.8521	0.8521
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	3.07	3.07	-0.48	-0.48	2.38	2.38	-1.44	-1.44	1.73	1.73	-1.30	-1.30
Equity Financing Ratio	2.02	2.02	3.20	3.20	1.96	1.96	3.65	3.65	2.28	2.28	4.26	4.26
D. Additional Statistics												
Income from Operations	1,561,156	2,776,068	(2,462,226)	(597,021)	193,077	3,070,117	(1,965,465)	(2,562,482)	(1,751,406)	1,318,712	(1,527,890)	(4,088,302)
Revenue Over/(Under) Expense	1,009,561	(200,371)	(3,416,236)	(4,210,292)	(208,023)	(307,422)	(2,426,593)	(6,636,881)	(2,311,491)	(2,618,911)	(2,281,393)	(8,916,203)
EBITDA	1,561,156	2,776,068	(2,462,226)	(597,021)	193,077	3,070,117	(1,965,465)	(2,562,482)	(1,751,406)	1,318,712	(1,527,890)	(4,088,302)
Patient Cash Collected	23,134,663	146,670,325	20,142,893	141,025,765	20,385,383	167,055,709	18,367,715	159,393,480	20,431,608	187,487,316	19,949,375	179,342,855
Cash and Cash Equivalents	28,211,027	28,211,027	19,973,015	19,973,015	22,985,041	22,985,041	20,561,276	20,561,276	25,158,418	25,158,418	22,002,562	22,002,562
Net Working Capital	28,980,645	28,980,645	23,325,453	23,325,453	27,927,063	27,927,063	21,016,187	21,016,187	23,852,861	23,852,861	16,603,661	16,603,661
Unrestricted Assets	39,376,425	39,376,425	25,529,619	25,529,619	38,925,347	38,925,347	23,087,146	23,087,146	36,343,160	36,343,160	20,585,575	20,585,575
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Total GWHN

	Month of Jul-14	Y-T-D 07/31/14	Month of Jul-15	Y-T-D 07/31/15	Month of Aug-14	Y-T-D 08/31/14	Month of Aug-15	Y-T-D 08/31/15
A. Operating Performance								
Operating Margin	-4.04%	-3.03%	-20.71%	-6.77%	-6.81%	-3.31%	-14.10%	-7.39%
Non-Operating Margin	-3.17%	-1.80%	-19.90%	-5.81%	-5.61%	-2.12%	-13.35%	-6.45%
Total Margin	-3.72%	-1.62%	-19.53%	-5.97%	-4.63%	-1.88%	-15.30%	-6.77%
Bad Debt as % Gross Revenue	-2.80%	0.16%	1.02%	0.39%	0.79%	0.21%	0.85%	0.43%
B. Liquidity								
Current Ratio	1.68	1.68	0.97	0.97	1.79	1.79	1.03	1.03
Days Cash on Hand	59.77	59.77	41.80	41.80	54.40	54.40	39.66	39.66
Days in Net Accounts Receivables	50.26	50.26	60.18	60.18	53.72	53.72	59.94	59.94
Average Payment Period	45.69	45.69	43.83	43.83	41.18	41.18	43.69	43.69
C. Leverage and Capital Structure								
Long-term Debt to Equity	0.7431	0.7431	1.5119	1.5119	0.7707	0.7707	1.8978	1.8978
Long-term Debt to Capitalization	0.4263	0.4263	0.6019	0.6019	0.4353	0.4353	0.6549	0.6549
Unrestricted Cash to Debt	1.0410	1.0410	0.1171	0.1171	0.8984	0.8984	0.1166	0.1166
Times Interest Earned Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Coverage Ratio	1.34	1.34	-2.72	-2.72	0.99	0.99	-3.31	-3.31
Equity Financing Ratio	2.38	2.38	5.16	5.16	2.40	2.40	6.56	6.56
D. Additional Statistics								
Income from Operations	(178,926)	1,025,260	(3,486,774)	(7,575,080)	(705,922)	402,465	(2,119,606)	(9,694,688)
Revenue Over/(Under) Expense	(868,438)	(3,603,719)	(3,946,434)	(12,862,636)	(1,002,893)	(4,581,472)	(3,064,172)	(15,926,812)
EBITDA	(178,926)	1,025,260	(3,486,774)	(7,575,080)	(705,922)	402,465	(2,119,606)	(9,694,688)
Patient Cash Collected	20,638,288	208,125,604	21,041,111	200,383,967	19,923,196	228,048,799	19,137,425	219,521,392
Cash and Cash Equivalents	28,151,297	28,151,297	3,010,785	3,010,785	24,214,495	24,214,495	2,978,798	2,978,798
Net Working Capital	23,732,718	23,732,718	(1,022,164)	(1,022,164)	25,115,685	25,115,685	1,012,991	1,012,991
Unrestricted Assets	35,190,459	35,190,459	16,415,945	16,415,945	33,840,369	33,840,369	13,002,038	13,002,038
Credit Ratings (S&P, FITCH and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

EXHIBIT Q51-1

IRS TAX FORM 990 FILED BY GWHN FOR TAX YEAR 2014

MARCUM
ACCOUNTANTS ▲ ADVISORS

AUGUST 12, 2015

BARBARA HALLINAN
THE WATERBURY HOSPITAL
64 ROBBINS STREET
WATERBURY, CT 06708

DEAR BARBARA:

ENCLOSED ARE THE ORGANIZATION'S 2013 EXEMPT ORGANIZATION RETURNS. THE STATE EXEMPT ORGANIZATION RETURN IS ALSO ENCLOSED. THESE SHOULD BE SIGNED, DATED, AND MAILED, AS INDICATED.

SPECIFIC FILING INSTRUCTIONS ARE AS FOLLOWS.

FORM 990 RETURN:

THIS RETURN HAS QUALIFIED FOR ELECTRONIC FILING. AFTER YOU HAVE REVIEWED THE RETURN FOR COMPLETENESS AND ACCURACY, PLEASE SIGN, DATE AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL TRANSMIT THE RETURN ELECTRONICALLY TO THE IRS AND NO FURTHER ACTION IS REQUIRED. RETURN FORM 8879-EO TO US BY AUGUST 17, 2015.

FORM 990-T RETURN:

NO AMOUNT IS DUE ON FORM 990-T.

PLEASE SIGN AND MAIL ON OR BEFORE AUGUST 17, 2015.

MAIL TO - DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE CENTER
OGDEN, UT 84201-0027

CONNECTICUT FORM CT-990T RETURN:

MAIL TO - DEPARTMENT OF REVENUE SERVICES
STATE OF CONNECTICUT
PO BOX 5014
HARTFORD, CT 06102-5014

PLEASE SIGN AND MAIL FORM CT-990T ON OR BEFORE AUGUST 17, 2015.

NO PAYMENT IS REQUIRED.

WE RECOMMEND THAT YOU USE CERTIFIED MAIL WITH POST MARKED RECEIPT FOR PROOF OF TIMELY FILING.

COPIES OF ALL THE RETURNS ARE ENCLOSED FOR YOUR FILES. WE SUGGEST THAT YOU RETAIN THESE COPIES INDEFINITELY.

VERY TRULY YOURS,

DOUGLAS FARRINGTON
MARCUM LLP

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2013, or fiscal year beginning OCT 1 , 2013, and ending SEP 30 ,20 14

▶ **Do not send to the IRS. Keep for your records.**

▶ **Information about Form 8879-EO and its instructions is at** *www.irs.gov/form8879eo*

OMB No. 1545-1878

2013

Name of exempt organization

THE WATERBURY HOSPITAL

Employer identification number

06-0665979

Name and title of officer

DARLENE STROMSTAD
PRESIDENT/TREASURER

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a Form 990 check here ▶ [X]	**b Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	234,229,162.
2a Form 990-EZ check here ▶ [ ]	**b Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a Form 1120-POL check here ▶ [ ]	**b Total tax** (Form 1120-POL, line 22)	**3b**	
4a Form 990-PF check here ▶ [ ]	**b Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a Form 8868 check here ▶ [ ]	**b Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2013 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize MARCUM LLP to enter my PIN 65979

ERO firm name

Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 06411606103

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2013 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ **Do not enter Social Security numbers on this form as it may be made public.**

▶ **Information about Form 990 and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning OCT 1, 2013 **and ending** SEP 30, 2014

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
THE WATERBURY HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) — Room/suite
64 ROBBINS STREET

City or town, state or province, country, and ZIP or foreign postal code
WATERBURY, CT 06708

F Name and address of principal officer: DARLENE STROMSTAD
SAME AS C ABOVE

D Employer identification number
06-0665979

E Telephone number
(203)573-6000

G Gross receipts $ 242,115,744.

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.WATERBURYHOSPITAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1951 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: WATERBURY HOSPITAL'S MISSION IS TO PROVIDE COMPASSIONATE HIGH QUALITY HEALTH CARE SERVICES THROUGH A

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	15
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	1842
6	Total number of volunteers (estimate if necessary)	6	81
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	561,769.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-47,028.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	5,113,352.	5,854,966.
9	Program service revenue (Part VIII, line 2g)	224,908,774.	218,850,300.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	3,022,281.	3,485,660.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	6,628,390.	6,038,236.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	239,672,797.	234,229,162.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	119,976,501.	117,637,949.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 423,137.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	115,353,231.	114,190,591.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	235,329,732.	231,828,540.
19	Revenue less expenses. Subtract line 18 from line 12	4,343,065.	2,400,622.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	170,955,068.	172,168,042.
21	Total liabilities (Part X, line 26)	84,816,366.	91,192,245.
22	Net assets or fund balances. Subtract line 21 from line 20	86,138,702.	80,975,797.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ DARLENE STROMSTAD, PRESIDENT/TREASURER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
DOUGLAS FARRINGTON			☐	P00370668

Firm's name ▶ MARCUM LLP — Firm's EIN ▶ 11-1986323

Firm's address ▶ CITY PLACE II 185 ASYLUM STREET
HARTFORD, CT 06103 — Phone no. 860-760-0600

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
WATERBURY HOSPITAL'S MISSION IS TO PROVIDE COMPASSIONATE HIGH QUALITY HEALTH CARE SERVICES THROUGH A FAMILY OF PROFESSIONALS AND SERVICES.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 192,231,293. including grants of $) (Revenue $ 224,304,746.)
STATEMENT OF PURPOSE

AS A NOT-FOR-PROFIT COMMUNITY HOSPITAL, WATERBURY HOSPITAL PROVIDES QUALITY HEALTH CARE TO ALL AREA INDIVIDUALS, REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, AGE, HANDICAP OR ABILITY TO PAY. HOWEVER, REIMBURSEMENT FOR SERVICES IS CRITICAL TO THE HOSPITAL'S STABILITY AND LONG-TERM OPERATION.

SEE SCHEDULE O FOR CONTINUATION

4b (Code:) (Expenses $ including grants of $) (Revenue $)

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 192,231,293.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a	X	
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	325		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1842		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a		X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year ..... If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	1a 15		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 10		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b		X

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ NONE

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☒ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

SCOTT BOWMAN - 203-573-7333

64 ROBBINS STREET, WATERBURY, CT 06708

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DARLENE STROMSTAD	40.00									
PRESIDENT/TREASURER	26.00	X		X				576,786.	0.	93,364.
(2) CARL D. CONTADINI	0.30									
CHAIRMAN	0.30	X		X				0.	0.	0.
(3) JOHN A. KELLY, JR.	0.30									
VICE CHAIRMAIN	0.30	X		X				0.	0.	0.
(4) ANDREW K. SKIPP	0.20									
SECRETARY	0.20	X		X				0.	0.	0.
(5) CARL B. SHERTER, MD	7.00									
DIRECTOR	0.30	X						18,750.	0.	0.
(6) RON J. D'ANDREA, MD	0.20									
DIRECTOR	0.20	X						0.	0.	0.
(7) DR. HENRY BORKOWSKI	40.30									
DIRECTOR / CAGW - CARDIOLOGIST	0.30	X						750,082.	0.	37,460.
(8) JAMES H. GATLING, PH.D	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(9) PATRICIA MCKINLEY	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(10) JOHN A. MICHAELS	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(11) DAVID J. PIZZUTO, MD	20.00									
DIRECTOR / VP MEDICAL SERVICES	7.00	X		X				173,784.	0.	8,431.
(12) WILLIAM J. PIZZUTO, PH.D	0.90									
DIRECTOR	0.90	X						0.	0.	0.
(13) DR. NEIL PETERSEN	7.00									
CHIEF OF STAFF	0.30	X						56,250.	0.	0.
(14) FRANK SHERER	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(15) SUNDAE BLACK	0.40									
DIRECTOR	0.40	X						0.	0.	0.
(16) SANDRA A. IADAROLA	40.00									
CHIEF NURSING OFFICER	2.10			X				250,887.	0.	16,691.
(17) DIANE M. WOOLLEY	40.00									
VP HUMAN RESOURCES	5.00			X				234,355.	0.	24,691.

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) MICHAEL J. CEMENO	40.00									
CHIEF INFORMATION OFFICER	7.00			X				354,243.	0.	22,504.
(19) THOMAS M. BURKE	40.00									
VICE PRESIDENT OPERATIONS	1.80			X				188,048.	0.	17,043.
(20) EDWARD ROMERO	40.00									
CHIEF FINANCIAL OFFICER	8.00			X				111,903.	0.	34,171.
(21) EHSAN ANSARI	40.00									
CAGW - CARDIOLOGIST						X		876,277.	0.	41,847.
(22) KEVIN KETT	40.00									
CAGW - CARDIOLOGIST						X		861,837.	0.	41,847.
(23) JOSEPH MORLEY	40.00									
CAGW - CARDIOLOGIST						X		884,876.	0.	41,847.
(24) MARK RUGGIERO	40.00									
CAGW - CARDIOLOGIST						X		763,998.	0.	41,370.
(25) STEPHEN WIDMAN	40.00									
CAGW - CARDIOLOGIST						X		783,391.	0.	41,847.
1b Sub-total ▶								6,885,467.	0.	463,113.
c Total from continuation sheets to Part VII, Section A ▶								0.	0.	0.
d Total (add lines 1b and 1c) ▶								6,885,467.	0.	463,113.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 140

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
SODEXO, INC. AND AFFILIATES P.O. BOX 360170, PITTSBURGH, PA 15251-6170	DIETARY, BUILDING SVCS, TRANSPORT	4,455,266.
YALE UNIVERSITY P.O. BOX 208087, NEW HAVEN, CT 06520-8087	CLINICAL SERVICES	3,311,580.
CROTHALL HEALTHCARE 1500 LIBERTY RIDGE DRIVE, WAYNE, PA 19087	BUILDING SVCS, TRANSPORT SVCS	2,974,633.
MORRISON HEALTHCARE, 5801 PEACHTREE DUNWOODY RD, ATLANTA, GA 30342	DIETARY SERVICES	2,212,473.
CERNER CORPORATION, 2800 ROCKCREEK PARKWAY, KANSAS CITY, MO 64117	INFORMATION TECHNOLOGY	1,663,762.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 62

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e	4,369,303.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,485,663.				
	g Noncash contributions included in lines 1a-1f: $ 10,000.						
	h **Total.** Add lines 1a-1f ▶			5,854,966.			
Program Service Revenue		**Business Code**					
	2a NET PATIENT SERVICE REVENUE	624100		211,757,869.	211,757,869.		
	b CAW - NET PATIENT SERVICE REVENUE	621110		6,530,662.	6,530,662.		
	c LAB SERVICE REVENUE	621500		361,940.		361,940.	
	d IMAGE REPAIRS & MAINTENANCE	541900		199,829.		199,829.	
	e						
	f All other program service revenue						
	g **Total.** Add lines 2a-2f ▶			218,850,300.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶			2,933,557.			2,933,557.
	4 Income from investment of tax-exempt bond proceeds ▶						
	5 Royalties ▶						
		(i) Real	(ii) Personal				
	6a Gross rents	443,052.					
	b Less: rental expenses	0.					
	c Rental income or (loss)	443,052.					
	d Net rental income or (loss) ▶			443,052.			443,052.
		(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory	8,288,813.					
	b Less: cost or other basis and sales expenses	7,725,938.	10,772.				
	c Gain or (loss)	562,875.	-10,772.				
	d Net gain or (loss) ▶			552,103.			552,103.
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a	275,775.				
	b Less: direct expenses	b	149,872.				
	c Net income or (loss) from fundraising events ▶			125,903.			125,903.
	9a Gross income from gaming activities. See Part IV, line 19	a					
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities ▶						
	10a Gross sales of inventory, less returns and allowances	a					
	b Less: cost of goods sold	b					
	c Net income or (loss) from sales of inventory ▶						
	Miscellaneous Revenue	**Business Code**					
	11a CAW - OTHER INCOME	621110		1,762,014.	1,762,014.		
	b PARTNERSHIPS	900099		1,736,142.	1,736,142.		
	c MEANINGFUL USE INCOME	900099		1,507,510.	1,507,510.		
	d All other revenue	900099		463,615.	448,780.		14,835.
	e **Total.** Add lines 11a-11d ▶			5,469,281.			
	12 **Total revenue.** See instructions. ▶			234,229,162.	223,742,977.	561,769.	4,069,450.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	3,170,788.	659,105.	2,511,683.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	89,903,497.	83,785,315.	5,955,707.	162,475.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	4,737,029.	4,330,381.	397,864.	8,784.
9 Other employee benefits	13,143,592.	11,993,207.	1,125,748.	24,637.
10 Payroll taxes	6,683,043.	6,057,775.	612,986.	12,282.
11 Fees for services (non-employees):				
a Management				
b Legal	1,686,113.	136,931.	1,549,182.	
c Accounting	228,878.		228,878.	
d Lobbying	108,506.		108,506.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	407,116.		407,116.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	50,206,311.	38,807,958.	11,396,754.	1,599.
12 Advertising and promotion	701,405.	32,349.	669,056.	
13 Office expenses	10,282,481.	8,261,831.	1,997,490.	23,160.
14 Information technology				
15 Royalties				
16 Occupancy	4,793,989.	1,271,485.	3,522,504.	
17 Travel	99,088.	49,590.	46,621.	2,877.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	98,590.	91,816.	6,774.	
20 Interest	1,352,572.		1,352,572.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	6,998,818.		6,998,818.	
23 Insurance	6,945,049.	6,945,049.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL/SURGICAL SUPPLI	25,414,234.	25,414,234.		
b BAD DEBT	3,826,557.	3,826,557.		
c FOOD	372,699.	335,118.	37,581.	
d DUES AND SUBSCRIPTIONS	310,735.	106,101.	204,040.	594.
e All other expenses	357,450.	126,491.	44,230.	186,729.
25 **Total functional expenses.** Add lines 1 through 24e	231,828,540.	192,231,293.	39,174,110.	423,137.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	554,115.	1	3,350,462.
	2	Savings and temporary cash investments	24,214,034.	2	25,198,842.
	3	Pledges and grants receivable, net	3,198,969.	3	3,751,232.
	4	Accounts receivable, net	24,894,454.	4	26,880,306.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	3,418,629.	8	3,697,723.
	9	Prepaid expenses and deferred charges	1,414,532.	9	1,627,875.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 268,299,225.			
	b	Less: accumulated depreciation — 10b: 236,745,837.	37,464,222.	10c	31,553,388.
	11	Investments - publicly traded securities	12,387,068.	11	12,842,247.
	12	Investments - other securities. See Part IV, line 11	60,522,477.	12	60,513,519.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets	1,813,567.	14	1,813,567.
	15	Other assets. See Part IV, line 11	1,073,001.	15	938,881.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	170,955,068.	16	172,168,042.
Liabilities	17	Accounts payable and accrued expenses	26,958,532.	17	29,601,547.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	24,755,656.	20	24,283,520.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	33,102,178.	25	37,307,178.
	26	**Total liabilities.** Add lines 17 through 25	84,816,366.	26	91,192,245.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	29,976,833.	27	23,336,473.
	28	Temporarily restricted net assets	8,409,794.	28	8,729,527.
	29	Permanently restricted net assets	47,752,075.	29	48,909,797.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	86,138,702.	33	80,975,797.
	34	Total liabilities and net assets/fund balances	170,955,068.	34	172,168,042.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	234,229,162.
2	Total expenses (must equal Part IX, column (A), line 25)	2	231,828,540.
3	Revenue less expenses. Subtract line 2 from line 1	3	2,400,622.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	86,138,702.
5	Net unrealized gains (losses) on investments	5	118,716.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-7,682,243.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	80,975,797.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII X

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization	**Employer identification number**
THE WATERBURY HOSPITAL	06-0665979

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ..... ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	**11g(i)**	
(ii)	A family member of a person described in (i) above?	**11g(ii)**	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	**11g(iii)**	

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
Total									

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ..... ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) ..... 14 %

15 Public support percentage from 2012 Schedule A, Part II, line 14 ..... 15 %

16a **33 1/3% support test - 2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ..... ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2012** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2013.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at www.irs.gov/form990 .

OMB No. 1545-0047

2013

Name of the organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	☒ 501(c)(3) (enter number) organization
	☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	☐ 527 political organization
Form 990-PF	☐ 501(c)(3) exempt private foundation
	☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation
	☐ 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

☒ For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

☐ For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of $5,000 or more during the year ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	CARMODY, TORRANCE, SANDAK & HENNESSEY LLP 50 LEAVENWORTH STREET WATERBURY, CT 06721	$ 40,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2	CLY-DEL MANUFACTURING CO. 151 SHARON ROAD WATERBURY, CT 06721	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3	CONNECTICARE, INC. 175 SCOTT SWAMP RD. FARMINGTON, CT 06034-4050	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4	ION BANK FOUNDATION 251 CHURCH STREET NAUGATUCK, CT 06770	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5	ONYX JEWELERS 683 MAIN STREET WATERTOWN, CT 06795	$ 10,000.	Person [ ] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
6	THE HAROLD LEEVER REGIONAL CANCER CENTER 1075 CHASE PARKWAY WATERBURY, CT 06708	$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	WATERBURY HOSPITAL AUXILIARY, INC. 64 ROBBINS STREET WATERBURY, CT 06708	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8	COCA-COLA REFRESHMENTS 80 RADO DRIVE NAUGATUCK, CT 06770	$ 11,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
9	CROTHALL HEALTHCARE 1500 LIBERTY RIDGE DRIVE WAYNE, PA 19087-5583	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
10	DIAGOSTIC RADIOLOGY ASSOCIATES, INC. 134 GRANDVIEW AVENUE WATERBURY, CT 06708	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
11	HARTNETT FOUNDATION 385 SOUTH STREET MIDDLEBURY, CT 06762-3523	$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
12	ESTATE OF JOSEPH KEZELEVICH ONE WEST FOURTH STREET WINSTON-SALEM, NC 27101	$ 22,739.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	ESTATE OF MADELYN QUEOR C/O FARRELL, GEENTY, SHEELEY, BOCCALATTE & GUARINO PC, 141 BROAD ST. MIDDLETOWN, CT 06457	$ 107,157.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
14	TRUST OF DOROTHEA C. RICH 574 HERITAGE ROAD SOUTHBURY, CT 06488	$ 40,460.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
15	ROLLER BEARING COMPANY OF AMERICA, INC. 102 WILLENBROCK ROAD OXFORD, CT 06478	$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
16	RONALD MCDONALD HOUSE CHARITIES OF CT & WESTERN MA CHAPTER 501 GEORGE STREET NEW HAVEN, CT 06511	$ 12,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
17	ESTATE OF FERN VERRIKER C/O US TRUST - BANK OF AMERICA 200 GLASTONBURY BLVD. - 2ND FLOOR GLASTONBURY, CT 06033	$ 193,573.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
18	THE DAVID, HELEN & MARIAN WOODWARD FUND P.O. BOX 817 WATERTOWN, CT 06795	$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	HYGRADE BUSINESS GROUP, INC. 1525 HAMILTON AVENUE WATERBURY, CT 06706	$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
5	JEWELRY	$ 10,000.	12/04/13
		$	
		$	
		$	
		$	
		$	
		$	

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year. Complete columns **(a)** through **(e)** and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **See separate instructions.** ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
THE WATERBURY HOSPITAL	06-0665979

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures ▶ $
3 Volunteer hours

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?	X		
d Mailings to members, legislators, or the public?	X		
e Publications, or published or broadcast statements?	X		
f Grants to other organizations for lobbying purposes?	X		60,000.
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?	X		
i Other activities?	X		48,506.
j Total. Add lines 1c through 1i			108,506.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

A PORTION OF THE CT HOSPITAL ASSOCIATION AND AMERICAN HOSPITAL ASSOCIATION FEES THAT ARE PAID BY THE WATERBURY HOSPITAL IS FOR LOBBYING ACTIVITIES. THE WATERBURY HOSPITAL ALSO PAYS ROY AND LEROY LLC FOR LOBBYING SERVICES TOTALING $60,000.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).
☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	58,391,891.	54,791,385.	48,442,875.	51,457,624.	49,308,865.
b Contributions					20.
c Net investment earnings, gains, and losses	2,214,558.	4,160,381.	6,884,672.	-2,784,813.	2,729,359.
d Grants or scholarships					
e Other expenditures for facilities and programs	773,967.	559,875.	536,162.	229,936.	580,620.
f Administrative expenses					
g End of year balance	59,832,482.	58,391,891.	54,791,385.	48,442,875.	51,457,624.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 5.54 %
b Permanent endowment ▶ 81.75 %
c Temporarily restricted endowment ▶ 12.71 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)	X	
(ii) related organizations	3a(ii)		X
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		287,549.		287,549.
b Buildings		86,691,215.	71,666,585.	15,024,630.
c Leasehold improvements		654,276.	487,682.	166,594.
d Equipment		177,982,606.	162,263,411.	15,719,195.
e Other		2,683,579.	2,328,159.	355,420.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				31,553,388.

Schedule D (Form 990) 2013

332052
09-25-13

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD IN TRUST BY		
(B) OTHERS	46,117,761.	END-OF-YEAR MARKET VALUE
(C) GREATER WATERBURY IMAGING		
(D) CENTER	3,790,798.	END-OF-YEAR MARKET VALUE
(E) ACCESS REHAB CENTERS	4,927,550.	END-OF-YEAR MARKET VALUE
(F) IMAGING PARTNERS	434,844.	END-OF-YEAR MARKET VALUE
(G) ALLIANCE MEDICAL GROUP	5,242,566.	END-OF-YEAR MARKET VALUE
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	60,513,519.	

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	

Part X Other Liabilities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) LIABILITIES OF CONSOLIDATED	
(3) AFFILIATES	2,048,387.
(4) RESERVE FOR WORKER'S	
(5) COMP/MALPRACTICE LIAB. LOSS	13,249,306.
(6) NONCONTROLLING INTEREST	2,716,294.
(7) DEFERRED LIAB. ON GIFT ANNUITY	108,707.
(8) ASSET RETIREMENT OBLIGATION	2,801,923.
(9) CAPITAL LEASE LIABILITY	820,591.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	37,307,178.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	262,082,503.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a	118,716.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	29,940,684.		
e	Add lines **2a** through **2d**			2e	30,059,400.
3	Subtract line **2e** from line **1**			3	232,023,103.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	407,116.		
b	Other (Describe in Part XIII.)	4b	1,798,943.		
c	Add lines **4a** and **4b**			4c	2,206,059.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	234,229,162.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	266,851,958.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d	35,430,534.		
e	Add lines **2a** through **2d**			2e	35,430,534.
3	Subtract line **2e** from line **1**			3	231,421,424.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	407,116.		
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	407,116.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	231,828,540.

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4:

THE ENDOWMENT FUNDS ARE USED FOR FREE CARE AND GENERAL HOSPITAL OPERATIONS.

PART X, LINE 2:

THE HOSPITAL IS A NOT-FOR-PROFIT CORPORATION AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AND IS EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE. THE HOSPITAL IS ALSO EXEMPT FROM STATE INCOME TAXES. ACCESS, GWIC, CAGW, AND IMAGING PARTNERS LLC ARE PARTNERSHIPS. FOR TAX PURPOSES, THESE PARTNERSHIP ARE PASS-THROUGH ENTITIES. TAXATION DOES NOT OCCUR AT THE PARTNERSHIP LEVEL. ACCORDINGLY, NO PROVISION FOR TAXES IS INCLUDED. AMG IS TAX EXEMPT

Part XIII Supplemental Information *(continued)*

UNDER SECTION 501(C)(3) OF THE CODE.

MANAGEMENT HAS ANALYZED THE TAX POSITIONS TAKEN AND HAS CONCLUDED THAT AS OF SEPTEMBER 30, 2014, THERE ARE NO UNCERTAIN TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN IN THAT WOULD REQUIRE RECOGNITION OF A LIABILITY (OR ASSET) OR DISCLOSURE IN THE FINANCIAL STATEMENTS. THE HOSPITAL IS SUBJECT TO ROUTINE AUDITS BY TAXING JURISDICTIONS; HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS IN PROGRESS. MANAGEMENT BELIEVES THE HOSPITAL IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS PRIOR TO 2011.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

INCOME FROM CONSOLIDATED AFFILIATES	29,790,812.
FUNDRAISING EXPENSE	149,872.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	29,940,684.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

INVESTMENT INCOME FROM PARTNERSHIP	1,736,142.
WATERBURY GASTROENTEROLOGY INCOME	62,801.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	1,798,943.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

EXPENSE OF CONSOLIDATED AFFILIATES	35,280,662.
FUNDRAISING EXPENSE	149,872.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	35,430,534.

Part XIII Supplemental Information *(continued)*

Part X Other Liabilities. See Form 990, Part X, line 25.

(a) Description of liability	(b) Amount
ACCRUED PENSION LIABILITY	6,860,268.
DEFERRED LIAB. ON SERP	330,148.
SWAP RATE LIABILITY	1,512,596.
DUE TO AFFILIATES	2,386,118.
DUE TO THIRD-PARTY REIMBURSEMENT AGENCIES	4,171,981.
SODEXO LIABILITY	300,859.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule G (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a ☐ Mail solicitations
b ☐ Internet and email solicitations
c ☐ Phone solicitations
d ☐ In-person solicitations
e ☐ Solicitation of non-government grants
f ☐ Solicitation of government grants
g ☐ Special fundraising events

2 a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Total ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Part II **Fundraising Events.** Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than $15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than $5,000.

		(a) Event #1 GALA (event type)	(b) Event #2 GOLF TOURNAMENT (event type)	(c) Other events 1 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	142,035.	94,080.	39,660.	275,775.
	2 Less: Contributions				
	3 Gross income (line 1 minus line 2)	142,035.	94,080.	39,660.	275,775.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes		5,940.		5,940.
	6 Rent/facility costs	34,350.	20,379.	14,550.	69,279.
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	54,732.	4,812.	15,109.	74,653.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				149,872.
	11 Net income summary. Subtract line 3, column (d) ▶				125,903.

Part III **Gaming.** Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				
	8 Net gaming income summary. Subtract line 7 from line 1, column (d) ▶				

9 Enter the state(s) in which the organization operates gaming activities: _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____ .

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

Part IV **Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990 .

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other _____ %	3b	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			1378274.	559,653.	818,621.	.36%
b Medicaid (from Worksheet 3, column a)		47,294	44947471.	37027473.	7919998.	3.47%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		47,294	46325745.	37587126.	8738619.	3.83%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		38,050			9127921.	4.00%
f Health professions education (from Worksheet 5)		3,300	17393811.	8733484.	8660327.	3.80%
g Subsidized health services (from Worksheet 6)		2,421	10750684.	10162296.	588,388.	.26%
h Research (from Worksheet 7)		17			5,580.	.00%
i Cash and in-kind contributions for community benefit (from Worksheet 8)		112,275			108,982.	.05%
j **Total.** Other Benefits		156,063	28144495.	18895780.	18491198.	8.11%
k **Total.** Add lines 7d and 7j		203,357	74470240.	56482906.	27229817.	11.94%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support		11,969	13,163.		13,163.	.01%
4	Environmental improvements						
5	Leadership development and training for community members		414	326,775.	131,908.	194,867.	.09%
6	Coalition building		430	50,405.		50,405.	.02%
7	Community health improvement advocacy						
8	Workforce development						
9	Other			45,672.	29,936.	15,736.	.01%
10	**Total**		12,813	436,015.	161,844.	274,171.	.13%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	871,605.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	0.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	70,728,737.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	78,479,664.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-7,750,927.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a		X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 THE WATERBURY HOSPITAL 64 ROBBINS STREET WATERBURY, CT 06708	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group THE WATERBURY HOSPITAL

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url):			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[ ] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide plan			
d	[X] Participation in the execution of a community-wide plan			
e	[ ] Inclusion of a community benefit section in operational plans			
f	[ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	X	
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? **$**			

Part V Facility Information *(continued)* THE WATERBURY HOSPITAL

		Yes	No
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %			
If "No," explain in Section C the criteria the hospital facility used.			
11 Used FPG to determine eligibility for providing *discounted* care?	11	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
If "No," explain in Section C the criteria the hospital facility used.			
12 Explained the basis for calculating amounts charged to patients?	12	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a [X] Income level			
b [X] Asset level			
c [ ] Medical indigency			
d [ ] Insurance status			
e [ ] Uninsured discount			
f [ ] Medicaid/Medicare			
g [ ] State regulation			
h [ ] Residency			
i [ ] Other (describe in Section C)			
13 Explained the method for applying for financial assistance?	13	X	
14 Included measures to publicize the policy within the community served by the hospital facility?	14	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a [X] The policy was posted on the hospital facility's website			
b [X] The policy was attached to billing invoices			
c [X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d [X] The policy was posted in the hospital facility's admissions offices			
e [ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f [X] The policy was available on request			
g [ ] Other (describe in Section C)			
Billing and Collections			
15 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Section C)			
17 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a [ ] Reporting to credit agency			
b [ ] Lawsuits			
c [ ] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Section C)			

Part V Facility Information *(continued)* THE WATERBURY HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** [X] Notified individuals of the financial assistance policy on admission
- **b** [X] Notified individuals of the financial assistance policy prior to discharge
- **c** [X] Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** [X] Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** [ ] Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- **a** [ ] The hospital facility did not provide care for any emergency medical conditions
- **b** [ ] The hospital facility's policy was not in writing
- **c** [ ] The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** [ ] Other (describe in Section C)

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** [ ] The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** [ ] The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** [ ] The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** [X] Other (describe in Section C)

21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	21		X
22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	22		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

THE WATERBURY HOSPITAL:

PART V, SECTION B, LINE 3: COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION (2013 - 2016)

IN 2012, SEVERAL COMMUNITY ORGANIZATIONS CAME TOGETHER TO CONDUCT A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THESE ORGANIZATIONS FORMED THE GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP (GWHIP). THE INITIAL PARTNERS OF GWHIP INCLUDED WATERBURY HOSPITAL, SAINT MARY'S HOSPITAL, STAYWELL HEALTH CENTER, UNITED WAY OF GREATER WATERBURY, CONNECTICUT COMMUNITY FOUNDATION, AND THE WATERBURY DEPARTMENT OF HEALTH.

THE 2012 CHNA INCLUDED BOTH QUANTITATIVE AND QUALITATIVE DATA COLLECTION. FOR QUANTITATIVE DATA COLLECTION, A HOUSEHOLD TELEPHONE SURVEY WAS CONDUCTED ALONG WITH A KEY INFORMANT ONLINE SURVEY AND A REVIEW OF SECONDARY DATA. FOR QUALITATIVE DATA, GWHIP CONDUCTED FOCUS GROUPS WITH BOTH HEALTHCARE PROVIDERS AND HEALTHCARE CONSUMERS. THE RESEARCH WAS PRESENTED TO A GROUP OF COMMUNITY LEADERS WHO VOTED ON COMMUNITY HEALTH PRIORITIES. WATERBURY HOSPITAL THEN DEVELOPED AN IMPLEMENTATION STRATEGY BASED ON THE COMMUNITY HEALTH PRIORITIES. THE IMPLEMENTATION STRATEGY WAS ADOPTED BY THE WATERBURY HOSPITAL BOARD OF DIRECTORS ON SEPTEMBER 26, 2013.

GWHIP ESTABLISHED A STEERING COMMITTEE TO ADDRESS THE FOUR COMMUNITY HEALTH PRIORITIES: (1) ACCESS TO CARE; (2) MENTAL HEALTH AND SUBSTANCE ABUSE; (3) OBESITY AND CHRONIC DISEASES; AND (4) TOBACCO USE. WATERBURY HOSPITAL LEADERS PARTICIPATE ON THE GWHIP STEERING COMMITTEE WHICH MEETS

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

MONTHLY. OTHER WATERBURY HOSPITAL STAFF MEMBERS PARTICIPATE IN THE FOUR WORK GROUPS WHICH ALSO MEET MONTHLY. THE WORK GROUPS HAVE WORK PLANS, INCLUDING GOALS AND OBJECTIVES FOR THE THREE-YEAR PERIOD FOLLOWING THE INITIAL CHNA.

WATERBURY HOSPITAL IS PRESENTLY ADDRESSING THE IMPLEMENTATION STRATEGY THAT WAS ADOPTED BY THE BOARD ON SEPTEMBER 26, 2013. FOR EXAMPLE REGARDING THE OBESITY PRIORITY, WATERBURY HOSPITAL RECENTLY BEGAN OFFERING A FARMER'S MARKET ON-SITE FOR BOTH STAFF AND COMMUNITY MEMBERS. THE FARMER'S MARKET IS COORDINATED BY BRASS CITY HARVEST, WHICH IS A NON-PROFIT ORGANIZATION AND ITS STAFF MEMBERS ARE ACTIVELY INVOLVED IN GWHIP. WATERBURY HOSPITAL STAFF MEMBERS ARE ALSO INVOLVED IN THE PLANTING OF FRUIT AND VEGETABLE GARDENS ACROSS THE STREET FROM JONATHAN REED ELEMENTARY SCHOOL. STUDENTS AND PARENTS CAN HARVEST THE FRUITS AND VEGETABLES LATER IN THE SUMMER.

THE YOUTH PIPELINE PROGRAM IS ALSO TEACHING STUDENTS ABOUT FOOD AND HEALTHY EATING. THE HOSPITAL DIETICIAN LED A CLASS ON MAKING "EDIBLE ARRANGEMENTS." THE STUDENTS USED PINEAPPLES, STRAWBERRIES, GRAPES, AND BLUEBERRIES IN THIS EXERCISE. STUDENTS ALSO GOT HANDS ON EXPERIENCE PREPARING HEALTHY HOT AND COLD MEALS WHILE WORKING DIRECTLY WITH THE HOSPITAL NUTRITIONIST.

COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLANNING (2016 - 2019)

WATERBURY HOSPITAL HAS STARTED WORKING ON THE NEXT COMMUNITY HEALTH NEEDS

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

ASSESSMENT (CHNA). WATERBURY HOSPITAL WILL WORK WITH GWHIP ONCE AGAIN ON COMPLETING THE CHNA. WATERBURY HOSPITAL HAS CONTRIBUTED FINANCIALLY TOWARD THE CONNECTICUT WELLBEING SURVEY. THE CONNECTICUT WELLBEING SURVEY IS A TELEPHONE SURVEY ADMINISTERED BY DATAHAVEN, WHICH IS A NON-PROFIT ORGANIZATION WITH THE MISSION OF IMPROVING THE QUALITY OF LIFE BY COLLECTING, SHARING AND INTERPRETING PUBLIC DATA FOR EFFECTIVE DECISION MAKING.

DATAHAVEN WAS ACTIVELY INVOLVED IN YALE-NEW HAVEN HOSPITAL'S CHNA IN 2013 WHEN THE FIRST WELLBEING SURVEY WAS CONDUCTED IN THE NEW HAVEN REGION. THE 2015 - 2016 WELLBEING SURVEY WILL COVER THE ENTIRE STATE OF CONNECTICUT. GWHIP, INCLUDING WATERBURY HOSPITAL, CONTRIBUTED FINANCIAL RESOURCES TO DATAHAVEN SO THAT AN ADDITIONAL 1,100 PHONE CALLS WOULD BE MADE TO RESIDENTS IN WATERBURY HOSPITAL'S SERVICE AREA. THE ADDITIONAL PHONE CALLS WILL ALLOW GWHIP MEMBERS TO UNDERSTAND HEALTH AND WELLBEING ISSUES AT THE NEIGHBORHOOD LEVEL.

THE WELLBEING SURVEY QUESTIONS COVER TRADITIONAL HEALTH RELATED TOPICS. FOR EXAMPLE THE PHONE SURVEYOR ASKS "HAVE YOU EVER BEEN TOLD BY A HEALTH CARE PROVIDER THAT YOU HAVE DIABETES?" ANOTHER QUESTION IS "HAVE YOU EVER BEEN TOLD BY A HEALTH CARE PROVIDER THAT YOU HAVE HIGH CHOLESTEROL?" IN ADDITION TO THOSE HEALTH-RELATED QUESTIONS, THE WELLBEING SURVEY ALSO COVERS OTHER INDICATORS AROUND THE SOCIAL DETERMINANTS OF HEALTH. QUESTIONS COVER THE FOLLOWING AREAS: HOUSING, HEALTH, EDUCATION, CIVIC VITALITY, PUBLIC SAFETY AND ENVIRONMENTAL ISSUES.

WHILE THE WELLBEING SURVEY DATA WILL PROVIDE THE MAJORITY OF QUANTITATIVE

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

DATA FOR THE NEXT CHNA, GWHIP WILL ALSO DO A REVIEW OF SECONDARY DATA. WATERBURY HOSPITAL WILL WORK WITH GWHIP, INCLUDING SAINT MARY'S HOSPITAL, ON COLLECTING QUALITATIVE DATA SUCH AS FOCUS GROUP AND KEY INFORMANT INTERVIEWS. BOTH HOSPITALS TOGETHER WILL PRODUCE A CHNA THAT MEETS ALL IRS REQUIREMENTS. WATERBURY HOSPITAL WILL DEVELOP AN IMPLEMENTATION STRATEGY BASED ON THE QUANTITATIVE AND QUALITATIVE DATA COLLECTED. THIS IMPLEMENTATION STRATEGY WILL BE PRESENTED TO THE WATERBURY HOSPITAL BOARD OF DIRECTORS BY SEPTEMBER 30, 2016.

THE WATERBURY HOSPITAL:

PART V, SECTION B, LINE 4: ST. MARY'S HOSPITAL

THE WATERBURY HOSPITAL:

PART V, SECTION B, LINE 20D: ALL PATIENTS ARE CHARGED THE SAME.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 7

Name and address	Type of Facility (describe)
1 CARDIOLOGY ASSOCIATES OF GTR WATERBURY 455 CHASE PARKWAY WATERBURY, CT 06708	MEDICAL OFFICES, DIAGNOSTIC TESTING
2 BLOOD DRAW STATION 134 GRANDVIEW AVENUE WATERBURY, CT 06708	BLOOD DRAWING FACILITY
3 BLOOD DRAW STATION 1625 STRAITS TURNPIKE, SUITE 304 MIDDLEBURY, CT 06762	BLOOD DRAWING FACILITY/X-RAYS
4 BLOOD DRAW STATION 22 OLD WATERBURY ROAD, SUITE 201 SOUTHBURY, CT 06488	BLOOD DRAWING FACILITY
5 BLOOD DRAW STATION 130 SOUTH MAIN STREET THOMASTON, CT 06787	BLOOD DRAWING FACILITY
6 BLOOD DRAW STATION 51 DEPOT STREET, SUITE 212 WATERTOWN, CT 06795	BLOOD DRAWING FACILITY
7 BLOOD DRAW STATION 305 CHURCH STREET, SUITE 16 NAUGATUCK, CT 06770	BLOOD DRAWING FACILITY

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 3C:

N/A

PART I, LINE 6A:

YES, WATERBURY HOSPITAL DID PREPARE A COMMUNITY BENEFIT REPORT.

PART II, COMMUNITY BUILDING ACTIVITIES:

AS A LEADER IN THE DELIVERY OF HEALTHCARE SERVICES IN THE GREATER WATERBURY AREA, WATERBURY HOSPITAL (WH) IS COMMITTED TO STRENGTHENING THE WELFARE AND AWARENESS OF THE CITIZENS WITHIN ITS COMMUNITY. FROM STRENGTHENING THE CAREER PATHS OF WATERBURY AREA YOUTH; TO SUPPORTING THE UNINSURED AND UNDERINSURED THROUGH THE WATERBURY HEALTH ACCESS PROGRAM AND; PROVIDING TRANSPORT TO AND FROM MEDICAL APPOINTMENTS; WATERBURY HOSPITAL IS REMOVING THE BARRIERS TO QUALITY HEALTH CARE FOR ALL AND REMAINS FIRM IN ITS COMMITMENT TO A HEALTHIER, STRONGER, AND MORE PRODUCTIVE COMMUNITY.

Part VI Supplemental Information *(Continuation)*

KEY PROGRAMS:

YOUTH PIPELINE INITIATIVES: THE WATERBURY HOSPITAL YOUTH PIPELINE INITIATIVES WERE ESTABLISHED IN 2001 AS A PARTNERSHIP BETWEEN WATERBURY HOSPITAL AND WATERBURY PUBLIC SCHOOLS. THE MISSION OF THE PROGRAM IS TO CLOSE THE ACHIEVEMENT GAP FOR MINORITY AND ECONOMICALLY DISADVANTAGED STUDENTS IN WATERBURY SO THEY CAN MATRICULATE AND COMPETE NATIONALLY FOR PLACEMENT IN POST-SECONDARY EDUCATION PROGRAMS IN PREPARATION FOR HEALTH CAREERS. WATERBURY HOSPITAL IS COMMITTED TO ENHANCING AND ENRICHING THE ACADEMIC OPPORTUNITIES AND PERSONAL JOURNEYS OF OUR YOUTH, WHO ARE THE EMERGING WORKFORCE OF TOMORROW. TO THIS END, DURING 2014, WATERBURY HOSPITAL PROVIDED 129 STUDENTS AND PARENTS IN GREATER WATERBURY WITH UNIQUE EDUCATIONAL PROGRAMS THAT WILL ENHANCE THE OVERALL WELFARE OF OUR COMMUNITY.

THE WH YOUTH PIPELINE INITIATIVES HAD SIX FOCUS AREAS DURING FY 2014, INCLUDING:

- PARENT LEADERSHIP TRAINING INSTITUTE (PLTI) - IN 2014, SIX INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED WATERBURY'S PLTI, A 20-WEEK CURRICULUM TEACHING LEADERSHIP AND ADVOCACY SKILLS, AS WELL AS INDIVIDUAL COMMUNITY PROJECT PLANNING. PLTI'S CORE MISSION IS TO IMPART LEADERSHIP AND ADVOCACY SKILLS TO PARENTS WHILE SIMULTANEOUSLY EDUCATING THEM ABOUT VOLUNTEERISM, CIVIC LIFE, AND THE PROCESS BY WHICH STATE AND LOCAL GOVERNMENTS ENACT AND CHANGE LAWS.

- PARENTS SUPPORTING EDUCATIONAL EXCELLENCE (PSEE) - IN 2014, SEVENTEEN INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED WATERBURY'S PSEE, A 12-WEEK CURRICULUM CO-CREATED BY THE CONNECTICUT CENTER FOR SCHOOL

Part VI Supplemental Information *(Continuation)*

CHANGE AND THE CONNECTICUT COMMISSION ON CHILDREN FOR PARENTS (DEFINED BROADLY AS PARENTS, GUARDIANS, FAMILY MEMBERS AND GRANDPARENTS) TO INSTILL LEADERSHIP SKILLS IN EDUCATION AND TO FACILITATE PARTNERSHIPS BETWEEN SCHOOL STAFF AND PARENTS TO IMPROVE STUDENT LEARNING.

- UCONN PEOPLE EMPOWERING PEOPLE (PEP) OFFERED IN SPANISH AND ALBANIAN - BOTH FREE INAUGURAL PROGRAMS WERE HELD IN 2014. THE PROGRAMS INCLUDED A 10-WEEK PARENT LEADERSHIP AND ADVOCACY REGIMEN THROUGH WHICH 9 PARTICIPANTS SUCCESSFULLY COMPLETED THE ALBANIAN PORTION OF THE PEP COURSE AND 21 PARTICIPANTS COMPLETED THE SPANISH PORTION OF THE PEP COURSE. UCONN PEP IS A PERSONAL, FAMILY, AND LEADERSHIP DEVELOPMENT PROGRAM WITH A STRONG COMMUNITY FOCUS. PEP IS DESIGNED TO BUILD ON THE UNIQUE STRENGTHS AND LIFE EXPERIENCES OF PARTICIPANTS AND EMPHASIZES THE CONNECTION BETWEEN INDIVIDUAL AND COMMUNITY ACTION. BOTH UCONN PEP PROGRAMS ARE SIGNIFICANT FOR TWO REASONS; IT WAS THE FIRST TIME THAT A UCONN PEP COURSE HAS BEEN OFFERED IN BOTH ALBANIAN AND SPANISH AT WATERBURY HOSPITAL. HOWEVER IT IS ALSO THE FIRST TIME AN ALBANIAN AND SPANISH PARENT LEADERSHIP PROGRAM IS OFFERED WITH IN THE STATE OF CONNECTICUT. PARTICIPANTS OF BOTH PROGRAMS WORK INDIVIDUALLY OR COLLABORATIVELY TO CREATE A COMMUNITY PROJECT WHICH IS COMPLETED AS THE CONCLUDING PORTION OF THE PROGRAM. AN EXAMPLE OF A COMMUNITY PROJECT FROM 2014 INCLUDE: THE "UCONN ALBANIAN PEOPLE EMPOWERING PEOPLE (PEP) RESOURCE FAIR" THROUGH COLLABORATIVE EFFORT MEMBERS OF THE PLTI - ALBANIAN PEP ASSEMBLY REACHED OUT TO SENATOR JOAN HARTLEY IN AN EFFORT TO ADDRESS CHALLENGING LANGUAGE BARRIERS FACED BY MEMBERS OF THE COMMUNITY WHEN UTILIZING VARIOUS DMV SERVICES. TOGETHER THEY WERE ABLE TO BRING THESE CONCERNS TO THE ATTENTION OF CONNECTICUT LEGISLATIVES AND AS A RESULT ENACTED POSITIVE CHANGE FOR THE ALBANIAN COMMUNITY THROUGH THE CREATION OF A USER FRIENDLY COMMUNICATION INTERFACE ALLOWING THE OPTION OF

Part VI Supplemental Information *(Continuation)*

THE ALBANIAN LANGUAGE TO BE DISPLAYED ON VARIOUS FORMS AND WEB SERVICES.

- WH SUMMER BRIDGE PROGRAM - DURING THE SUMMER OF 2014, TWENTY-EIGHT STUDENTS FROM WATERBURY, GRADES 6-11, PARTICIPATED IN THE WH SUMMER BRIDGE PROGRAM. 100% OF MEALS WERE SECURED FOR THE PROGRAM FROM CITY OF WATERBURY SUMMER FOOD PROGRAM.

STUDENTS COMPLETED THE FOLLOWING MODULES:

- 12 HOURS OF MATH (PRE- ALGEBRA, ALGEBRA II, GEOMETRY AND CALCULUS) REVIEW SESSIONS

- 20 HOURS OF SAT WRITING AND VOCABULARY

- 18 HOURS OF PHOTOVOICE PROJECT, STUDENTS WERE INSTRUCTED ON PHOTOGRAPHY TECHNIQUES, COMPOSITION, AND EDITING USING ADOBE PHOTOSHOP SOFTWARE AND SLR CAMERAS

- 6 HOURS OF ESSAY WRITING

- 11 HOURS OF POETRY INSTRUCTION AND PARTICIPATION IN THE SECOND ANNUAL WH POETRY SLAM

- 8 HOURS OF JOB SHADOWING SESSIONS IN THE FOLLOWING DEPARTMENTS: NURSING, HEALTH INFORMATION MANAGEMENT, HUMAN RESOURCES, RESPIRATORY THERAPY, WATERBURY HEALTH ACCESS PROGRAM, MORRISON FOOD SERVICES & NUTRITION, FINANCE, INFECTIOUS DISEASES CLINIC, LAB, PHARMACY, CENTRAL SCHEDULING, PLANT ENGINEERING, HAROLD LEEVER REGIONAL CANCER CENTER, AMERICAN MEDICAL REPONSES, AND CLINICAL EDUCATION, WHICH INCLUDED PARTICIPATING IN CLASSES SPONSORED BY THE AMERICAN RED CROSS (CPR AND BABYSITTING).

- CPR & AMERICAN RED CROSS CERTIFIED BABYSITTING COURSE.

- 2 HOURS OF MS OFFICE COMPUTER SESSIONS

- 6 HOUR SCIENCE MODULE AT STONE ACADEMY

Part VI **Supplemental Information** *(Continuation)*

- 2 FULL-DAY FIELD TRIPS COMPLETED: ONE TO YALE UNIVERSITY FOR AN ADMISSIONS INFO SESSION AND CAMPUS TOUR AND ONE TO HAMMONASSET STATE PARK INCLUDING THREE EDUCATIONAL SESSIONS AT MEIGS POINT NATURE CENTER

- 2 HOURS OF COLLEGE ADMISSIONS PRESENTATIONS COMPLETED BY UCONN WATERBURY & NAUGATUCK VALLEY COMMUNITY COLLEGE

- 1 HOUR OF INDIVIDUAL ACADEMIC ADVISING

- 2 HOURS OF HR ORIENTATION & SOFT SKILLS TRAINING

- 10 HOURS OF SOCIAL DETERMINANTS OF HEALTH DOCUMENTARIES AND ACTIVE DISCUSSIONS WITH THE WATERBURY DEPARTMENT OF PUBLIC HEALTH

- PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) - SINCE ITS INCEPTION IN 2004, WATERBURY HOSPITAL'S PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) PROGRAM HAS ENGAGED ADMINISTRATORS, TEACHERS, AND STUDENTS FROM MIDDLE SCHOOLS IN GREATER WATERBURY TO ADDRESS PROJECTED SHORTAGES OF HEALTHCARE WORKERS AND TO CLOSE THE ACHIEVEMENT GAP FOR STUDENTS IN WATERBURY PUBLIC SCHOOLS. THROUGH THE PEACH PROGRAM, STUDENTS ENGAGE WITH HEALTHCARE WORKERS IN A NON-EMERGENCY SETTING AND ARE INFORMED OF THE VARIETY OF HEALTHCARE CAREER OPPORTUNITIES AVAILABLE IN OUR COMMUNITY. ANNUALLY, WATERBURY HOSPITAL ALSO OFFERS ITS PEACH SPRING BREAK EXPLORATION CAMP, THIS YEAR 48 MIDDLE SCHOOL STUDENTS FROM WATERBURY TOOK PART IN: SHADOWING AND HANDS-ON LEARNING ACTIVITIES AT THE HOSPITAL; CPR CERTIFICATION; BABYSITTING; AND EDUCATIONAL SESSIONS AT THE MYSTIC AQUARIUM.

SUPPORT GROUPS - DURING FISCAL YEAR 2014, WATERBURY HOSPITAL HOSTED SEVERAL SUPPORT GROUPS FOR ITS PATIENTS AND THEIR FAMILIES, INCLUDING:

- BEHAVIORAL HEALTH'S PARENT AND SIBLING SUPPORT GROUP, WHICH OFFERS EMOTIONAL ASSISTANCE TO FAMILIES WHO HAVE CHILDREN IN TREATMENT; AND

Part VI Supplemental Information *(Continuation)*

- ALCOHOLICS ANONYMOUS, SERVES OVER 4,000 PEOPLE ANNUALLY, MEETS WEEKLY THROUGHOUT THE YEAR, AND IS COORDINATED BY OUR BEHAVIORAL HEALTH DEPARTMENT.

PART III, LINE 2:

OVERALL COST TO CHARGE RATIO USED IN CALCULATION.

PART III, LINE 3:

FINANCIAL ASSISTANCE (CHARITY CARE) IS A SEPARATE NUMBER, AND NOT INCLUDED IN THE $871,605 ON LINE 2.

PART III, LINE 4:

THE HOSPITAL ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. A PATIENT IS CLASSIFIED AS A CHARITY PATIENT BY REFERENCE TO THE ESTABLISHED POLICIES OF THE HOSPITAL. ESSENTIALLY, THESE POLICIES DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO PAYMENT IS POSSIBLE. IN ASSESSING A PATIENT'S INABILITY TO PAY, THE HOSPITAL UTILIZES THE GENERALLY RECOGNIZED FEDERAL POVERTY INCOME LEVELS, BUT ALSO INCLUDES CERTAIN CASES WHERE INCURRED CHARGES ARE SIGNIFICANT WHEN COMPARED TO INCOMES AND ASSETS. THESE SERVICES ARE NOT INCLUDED IN NET PATIENT SERVICE REVENUES FOR FINANCIAL REPORTING PURPOSES. EFFECTIVE OCTOBER 1, 2013, THE HOSPITAL CHANGED ITS CHARITY CARE POLICY TO DISCOUNT ALL SELF PAY RECEIVABLES BY 50% UPON FINAL BILLING.

PART III, LINE 8:

COSTING METHODOLOGY USED TO COMPUTE THE MEDICARE SHORTFALL AND ANY ASSOCIATED COMMUNITY BENEFIT IS A COMBINATION OF THE AMOUNT REPORTED ON LINE 7 AS WELL AS THE HEALTH PROFESSION EDUCATION LINE. A

Part VI **Supplemental Information** *(Continuation)*

TOTAL SHORTFALL OF $7,750,927 WAS DERIVED FROM THE 2014 MEDICARE COST REPORT USING AN AHA APPROVED FORM FOR SCHEDULE H WORKSHEET B PPS AND IPF HOSPITALS. ALL OF THIS SHORTFALL SHOULD BE REPORTED AS A COMMUNITY BENEFIT. THE HOSPITAL COST ACCOUNTING SYSTEM SHOWS A SHORTFALL FROM ALL MEDICARE PROGRAMS (INCLUDING MANAGED MEDICARE) OF $12,528,626 (NET OF BAD DEBT AND FREE CARE).

PART III, LINE 9B:

WE HAVE SEVERAL CREDIT AND COLLECTION PROGRAMS GOVERNING PATIENTS WHO QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE; PROMPT PAY DISCOUNT; SLIDING SCALE; PAYMENT ARRANGEMENTS; CHARITY CARE AND FREE BED FUNDS. ANY PATIENT EXPRESSING DIFFICULTY PAYING A BALANCE IS ENTITLED TO APPLY FOR FINANCIAL COUNSELING ASSISTANCE. CUSTOMER SERVICE REPRESENTATIVES WORK WITH THE PATIENTS TO DETERMINE PROGRAM QUALIFICATION BASED ON THE COMPLETION OF A FINANCIAL APPLICATION. CASES ARE PREPARED AND PRESENTED TO THE PATIENT ASSISTANCE COMMITTEE. APPROVED CASES WILL BE EITHER FULLY OR PARTIALLY WRITTEN OFF TO FREE BED FUNDS OR CHARITY CARE.

PART VI, LINE 2:

WATERBURY HOSPITAL WORKS CLOSELY WITH LOCAL HEALTHCARE PROVIDERS AND COMMUNITY-BASED ORGANIZATIONS TO IDENTIFY HEALTHCARE NEEDS FOR UNDERSERVED PATIENTS THROUGHOUT THE WATERBURY COMMUNITY. THROUGH THESE COLLABORATIONS, WATERBURY HOSPITAL WORKS TO DEVELOP KEY PROGRAMMING FOR THE CITY'S VULNERABLE POPULATIONS, INCLUDING: THE WATERBURY HOSPITAL INFECTIOUS DISEASE CLINIC, WHICH PROVIDES COMPREHENSIVE HIV CARE TO ABOUT 500 PEOPLE LIVING WITH HIV/AIDS; THE WATERBURY HEALTH ACCESS PROGRAM, WHICH PROVIDES COMPREHENSIVE CASE MANAGEMENT SERVICES TO OVER 4,000 UNINSURED AND UNDERINSURED PATIENTS ANNUALLY; AND THE WATERBURY HOSPITAL

Part VI **Supplemental Information** *(Continuation)*

CHASE DIABETES DISEASE MANAGEMENT CLINIC, WHICH PROVIDES 60-70 DIABETICS WITH SELF-MANAGEMENT SKILLS AND CLINICAL CARE.

PART VI, LINE 3:

WE HAVE SIGNAGE, PT HANDBOOK, STATEMENT BACKERS & HANDOUTS THAT INFORM PATIENTS OF FREE BED FUNDS ETC. THE HOSPITAL ACCEPTS ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. A PATIENT IS CLASSIFIED AS A CHARITY PATIENT BY REFERENCE TO THE ESTABLISHED POLICIES OF THE HOSPITAL. ESSENTIALLY, THESE POLICIES DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO PAYMENT IS POSSIBLE. IN ASSESSING A PATIENT'S INABILITY TO PAY, THE HOSPITAL UTILIZES THE GENERALLY RECOGNIZED POVERTY INCOME LEVELS FOR THE STATE, BUT ALSO INCLUDES CERTAIN CASES WHERE INCURRED CHARGES ARE SIGNIFICANT WHEN COMPARED TO INCOMES. THESE CHARGES ARE NOT INCLUDED IN NET PATIENT SERVICE REVENUES FOR FINANCIAL REPORTING PURPOSES.

PART VI, LINE 4:

LOCATED IN A CITY OF 109,000 RESIDENTS, WATERBURY HOSPITAL IS CENTRALLY LOCATED IN WESTERN CONNECTICUT. IT IS ONE OF TWO HOSPITALS THAT SERVES THE CITY OF WATERBURY AND ITS SURROUNDING TOWNS, INCLUDING BEACON FALLS, BETHLEHEM, CHESHIRE, MIDDLEBURY, NAUGATUCK, PROSPECT, SOUTHBURY, THOMASTON, WATERTOWN, WOLCOTT, AND WOODBURY. OVERALL, THE CITY OF WATERBURY LAGS BEHIND THE STATE OF CONNECTICUT AND THE U.S. IN KEY MEASURABLE STATISTICS, AS SEEN IN TABLE 1, BELOW:

TABLE 1: SELECTED CENSUS DATA, JULY 2013, QUICKFACTS.CENSUS.GOV: WATERBURY, CT, & U.S.

	WATERBURY	CT	U.S.
MEDIAN HOUSEHOLD INCOME:	$40,639	$69,461	$52,762

Part VI **Supplemental Information** *(Continuation)*

PER CAPITA MONEY INCOME:	$21,120	$37,892	$27,915
% PERSONS BELOW POVERTY:	23.3%	10.2%	14.3%
% HOUSEHOLDS MARRIED COUPLE FAMILY:	34.6%	49.4%	49.7%
% OF OWNER-OCCUPIED HOMES:	47.4%	67.8%	66.9%
% FOREIGN-BORN PERSONS:	14.6%	13.6%	12.8%
% LANGUAGE NOT ENGLISH SPOKEN AT HOME, AGE 5+:	36.1%	21.5%	20.3%
% HOUSEHOLDS WITH NO VEHICLE:	16.8%	9.0%	8.8%
% MALE:	47.6%	48.7%	49.2%
% FEMALE	52.4%	51.3%	50.8%
% CAUCASIAN:	59.9%	77.9%	63.0%
% AFRICAN-AMERICAN:	19.8%	10.1%	13.1%
% HISPANIC:	33.8%	13.9%	16.9%
% HIGH SCHOOL GRADUATES OR HIGHER:	78.8%	89.2%	84.6%
% BACHELOR'S DEGREE OR HIGHER:	16.1%	36.5%	27.5%
% OF PERSONS AGE 65 & OVER:	10.5%	10.8%	13.7%
UNEMPLOYMENT RATE, MAY 2013:	8.7%	6.6%	7.6%
INFANT MORTALITY PER 1,000 RESIDENTS:	9.83	6.2	6.8
CRIME RATE (VIOLENT & PROPERTY) PER 100,000 RESIDENTS (2009):	6,379	2,981	3,466

WATERBURY WAS ONCE A ROBUST MANUFACTURING CENTER. HOWEVER, OVER THE PAST 25 YEARS, THE INDUSTRIAL BASE THAT WAS THE CENTER OF WATERBURY'S ECONOMY FOR MOST OF THE 20TH CENTURY DWINDLED, LEAVING MANY UNEMPLOYED. ALTHOUGH THERE ARE JOBS AVAILABLE IN HEALTHCARE AND SERVICE SECTORS, HIGH UNEMPLOYMENT REMAINS A THREAT FOR MANY INDIVIDUALS IN THE GREATER WATERBURY AREA. THE CITY OF WATERBURY IS ALSO DESIGNATED A FEDERAL MUA

Part VI **Supplemental Information** *(Continuation)*

(MEDICALLY UNDERSERVED AREA) AND HPSA (HEALTH PROFESSIONAL SHORTAGE AREA) FOR PRIMARY CARE, MENTAL HEALTH, AND DENTAL CARE.

PART VI, LINE 5:

REALIZING THE DIVERSE NEEDS OF RESIDENTS IN OUR COMMUNITY, WATERBURY HOSPITAL REMAINS DEDICATED TO PROVIDING COMPREHENSIVE HEALTH SERVICES TO ENSURE EVERY INDIVIDUAL HAS ACCESS TO APPROPRIATE, QUALITY HEALTHCARE.

DURING 2014, WATERBURY HOSPITAL'S SPECTRUM OF SERVICES CONTINUED TO HAVE A POSITIVE IMPACT ON THE WELFARE OF WATERBURY'S CITIZENS. TO REMAIN CONSISTENT WITH WATERBURY HOSPITAL'S MISSION, MANY OF OUR SERVICES ARE TARGETED FOR VULNERABLE MEMBERS OF OUR COMMUNITY, INCLUDING THOSE WHO ARE UNINSURED OR UNDERINSURED.

KEY PROGRAMS:

WATERBURY HEALTH ACCESS PROGRAM: WATERBURY HOSPITAL IS AWARE OF THE ECONOMIC NEEDS MANY PATIENTS IN OUR COMMUNITY, AND, AS A RESULT, WE REMAIN COMMITTED TO THE WATERBURY HEALTH ACCESS PROGRAM. FOUNDED IN 2003 AS A PARTNERSHIP BETWEEN WATERBURY HOSPITAL, ST. MARY'S HOSPITAL, STAYWELL HEALTH CENTER (FQHC), AND THE WATERBURY HEALTH DEPARTMENT, THE WATERBURY HEALTH ACCESS PROGRAM IMPROVES ACCESS TO HIGH-QUALITY MEDICAL CARE BY PROVIDING COMPREHENSIVE CASE MANAGEMENT, PHARMACY ASSISTANCE, AND ACCESS TO PRIMARY AND SUB-SPECIALTY MEDICAL CARE FOR THE UNINSURED AND UNDERINSURED RESIDENTS OF THE GREATER WATERBURY REGION. DURING FY 2014, THE WATERBURY HEALTH ACCESS PROGRAM HAD OVER 4,370 ACTIVE CLIENTS. ADDITIONALLY, WATERBURY HOSPITAL PROVIDED $402,864 WORTH OF DONATED

SERVICES TO WHAP'S PATIENTS.

BEHAVIORAL HEALTH - WATERBURY HOSPITAL'S CENTER FOR BEHAVIORAL HEALTH IS ONE OF THE REGION'S LARGEST SERVICE PROVIDERS OFFERING A FULL CONTINUUM OF CARE FOR CHILDREN, ADOLESCENTS AND ADULTS. OUR SERVICES ALSO OUTREACH TO THE COMMUNITY THROUGH REGULAR PARTICIPATION IN HEALTH FAIRS, ELECTED MEMBERSHIP IN THE NORTHWEST REGIONAL MENTAL HEALTH BOARD, AS A HOST SITE TO NUMEROUS TWELVE-STEP MEETINGS AND THE PROVISION OF CASE MANAGEMENT AS WELL AS ACUTE SERVICES TO THE HOMELESS WITHIN THE CITY OF WATERBURY. BEHAVIORAL HEALTH CLINICIANS CAN ENGAGE CLIENTS TO HELP FACILITATE THEIR ENTRANCE INTO TREATMENT. WE PROVIDE PHONE SUPPORT, REFERRALS AND TRIAGING TEN HOURS A DAY SEVEN DAYS A WEEK. WITHIN OUR CRISIS CENTER WE OFFER SHORT TERM SERVICES TO HELP INDIVIDUALS OBTAIN MORE PERMANENT TREATMENT THAT BEST MEETS THEIR NEEDS. AMBULATORY SERVICES INCLUDE PARTIAL HOSPITAL PROGRAMS, INTENSIVE OUTPATIENT SERVICES, GROUP, INDIVIDUAL THERAPY AND MEDICATION MANAGEMENT TO PATIENTS EXPERIENCING MENTAL ILLNESS AND/ OR A SUBSTANCE USE DISORDER. FOR INDIVIDUALS EXPERIENCING ACUTE SYMPTOMS WE OFFER INPATIENT TREATMENT TO ADOLESCENTS AGED 12 AND UP AS WELL AS ADULT SERVICES. OUR EFFORTS ARE AIMED AT PROMOTING THE BENEFITS OF CLINICAL TREATMENT AS WELL AS POSITIVE LIFESTYLE CHOICES. EVERY EFFORT IS MADE TO EDUCATE CLIENTS, THEIR FAMILIES AND THE COMMUNITY ABOUT MENTAL ILLNESS AND THE IMPACT TREATMENT CAN HAVE ON ONE'S ILLNESS. THE ULTIMATE GOAL IS TO HELP PEOPLE FEEL BETTER, REDUCE OR RESOLVE SYMPTOMS AND TO MINIMIZE THE STIGMA OF MENTAL ILLNESS.

BE WELL BUS - IN ORDER TO ENSURE THAT PATIENTS HAVE ACCESS TO MEDICAL APPOINTMENTS, AT THE HOSPITAL AND AT LOCAL PHYSICIANS' OFFICES, WATERBURY HOSPITAL'S BE WELL BUS PROVIDES TRANSPORTATION SERVICES TO PATIENTS FROM

Part VI Supplemental Information *(Continuation)*

WATERBURY AND ELEVEN OF ITS SURROUNDING TOWNS. DURING FY 2014, THE BE WELL BUS COMPLETED OVER 4,170 TRANSPORTS TO AND FROM MEDICAL APPOINTMENTS. WATERBURY HOSPITAL HAS CONTRACTED WITH A TRANSPORTATION PROVIDE TO OFFER THE BUS SERVICE, AND AREA PROVIDERS PAY A SMALL FEE TO PARTICIPATE.

HEART CENTER OF GREATER WATERBURY - FORMED IN COLLABORATION WITH SAINT MARY'S HOSPITAL, THE HEART CENTER OF GREATER WATERBURY PROVIDES DIVERSE MEDICAL SUPPORT INITIATIVES TO HELP EDUCATE RESIDENTS IN THE GREATER WATERBURY COMMUNITY ABOUT PERTINENT HEALTH AND WELLNESS ISSUES. THIS PAST YEAR, THE HEART CENTER CONDUCTED A SERIES OF HEALTH FAIRS AND VARIOUS HEALTH AND WELLNESS EDUCATION SESSIONS, INCLUDING "ASK THE NURSE," WHICH PROVIDES PATIENTS WITH COMPLIMENTARY BLOOD PRESSURE SCREENINGS AND HEALTH AWARENESS EDUCATION AND A "FREEDOM FROM SMOKING" SERIES TO HELP OUR RESIDENTS KICK THE HABIT.

FAMILY BIRTHING CENTER - PROVIDING A CHILD-CENTERED FOCUS, WATERBURY HOSPITAL'S FAMILY BIRTHING CENTER OFFERS EXPECTANT PARENTS A VARIETY OF CLASSES INCLUDING: BREAST FEEDING, CHILDBIRTH, AND INFANT CARE CLASSES TO PREPARE THEM FOR THEIR BABY'S ARRIVAL.

THANK GOD I'M FEMALE - FOR THE PAST 20 YEARS, WATERBURY HOSPITAL'S "THANK GOD I'M FEMALE" HAS SERVED AS AN ANNUAL WOMEN'S WELLNESS FORUM THAT FEATURES 40 EDUCATIONAL BOOTHS AND HEALTH-RELATED GIVEAWAYS. THE ULTIMATE GOAL OF THE FORUM IS TO EDUCATE ATTENDEES ABOUT STRESS, MENTAL WELL-BEING, HEART HEALTH, DIET, OSTEOPOROSIS AND BONE HEALTH, CHANGE OF LIFE, AND MORE. IN 2014, OVER 500 AREA RESIDENTS ATTENDED THE EVENT.

EVERGREEN 50 CLUB - WATERBURY HOSPITAL'S EVERGREEN 50 CLUB IS AN

Part VI Supplemental Information *(Continuation)*

ORGANIZATION COMPRISED OF OVER 15,000 MEMBERS OVER THE AGE OF 50. THE CLUB OFFERS WELLNESS PROGRAMMING, MEDICARE COUNSELING, AND HEALTH EDUCATION PRESENTATIONS ON A VARIETY OF TOPICS ARE PRESENTED BY HEALTH CARE PROFESSIONALS. PRESENTATION TOPICS INCLUDE: HOLISTIC HEALTH, VARICOSE VEIN TREATMENT, HEART DISEASE, SUMMER SKIN CARE, WEIGHT LOSS, BLOOD PRESSURE, BLADDER SCREENINGS, JOINT CARE AND REPLACEMENT, AND RESOLVING ADVERSE OUTCOMES WITH PATIENTS AND FAMILIES. ANNUALLY, THE EVERGREEN 50 CLUB HOSTS A HEALTH FAIR FOR ITS MEMBERS, WHICH PROVIDES FREE FLU SHOTS AND HEALTHCARE SCREENINGS.

WATERBURY HOSPITAL INFECTIOUS DISEASE CLINIC (WHIC) -
CURRENT SERVICES: THE WHIC OFFERS A COMPREHENSIVE "ONE-STOP SHOPPING" MODEL THAT PROVIDES PATIENTS WITH ON-SITE PRIMARY AND SPECIALTY SERVICES, MEDICAL CASE MANAGEMENT, INDIVIDUALIZED MEDICATION ADHERENCE SERVICES, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, NUTRITION COUNSELING, INDIVIDUALIZED HIV EDUCATION, LABORATORY TESTING, AND RADIOLOGY SERVICES. WHIC'S PROVIDERS INCLUDE THREE BOARD-CERTIFIED/BOARD-ELIGIBLE INFECTIOUS DISEASE SPECIALISTS AS WELL AS AN ADVANCED PRACTITIONER NURSE AND A REGISTERED DIETICIAN, ALL WITH EXPERTISE IN THE MANAGEMENT OF PATIENTS WITH HIV/AIDS. IN FY 2014, WHIC SERVED AROUND 500 PEOPLE LIVING WITH HIV/AIDS (PLWHA).

WHIC'S STAFF MEMBERS ACTIVELY PARTICIPATE IN STATEWIDE AND AREA COLLABORATIVE, SUCH AS THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC) AND THE RYAN WHITE PART A PLANNING COUNCIL, AND WHIC FACILITATES THE GREATER WATERBURY HIV CONSORTIUM. WHIC HAS A VERY ACTIVE CONSUMER ADVISORY GROUP (CAG), WHICH ORGANIZES SOCIAL AND TESTING EVENTS FOR THE COMMUNITY AND FACILITATES THE WATERBURY HOSPITAL PHOTOGRAPHY GROUP.

THE WHIC ALSO HAS A HEPATITIS C CLINIC, RUN BY AN ADVANCED PRACTITIONER NURSE. FROM OCTOBER 2004 TO PRESENT, NEARLY 200 HEPATITIS C MONO- AND CO-INFECTED (HEPATITIS C AND HIV) PATIENTS HAVE BEEN EVALUATED AT THE ID CLINIC. THE HEPATITIS C CLINIC PROVIDES A CONSULTATION WITH A NUTRITIONIST TO ADVISE ON HEALTHY EATING; COORDINATION WITH MENTAL HEALTH SERVICES; AND EDUCATIONAL SESSIONS ON SIDE EFFECT MANAGEMENT, THE IMPORTANCE OF HYDRATION AND ADHERENCE, AND POSITIVE COPING STRATEGIES.

FORGING COMMUNITY PARTNERSHIPS: SINCE 2009, THE WHIC HAS SERVED AS THE LEAD AGENCY FOR RYAN WHITE PART A FEDERAL FUNDING REGION 2 OF THE NEW HAVEN/FAIRFIELD ELIGIBLE METROPOLITAN AREA. THE WHIC WAS CHOSEN AS LEAD AGENCY BY THE CONSENSUS OF OTHER LOCAL RYAN WHITE PART A AGENCIES DUE TO ITS EXPERTISE IN PATIENT CARE AND FISCAL MANAGEMENT. AS THE LEAD AGENCY, THE WHIC HAS FORMED LONGSTANDING PARTNERSHIPS WITH STAYWELL HEALTH CENTER, INC., NEW OPPORTUNITIES, INC., RECOVERY NETWORK OF PROGRAMS, INC., AND CONNECTICUT COUNSELING CENTERS, INC., ALL OF WHOM WORK ALONGSIDE THE WHIC TO PROVIDE PATIENTS IN THE REGION WITH:

- PRIMARY HIV CARE;
- MEDICAL CASE MANAGEMENT;
- ORAL HEALTH CARE;
- INPATIENT AND OUTPATIENT SUBSTANCE ABUSE TREATMENT;
- HEALTH INSURANCE ASSISTANCE;
- MENTAL HEALTH;
- EARLY INTERVENTION SERVICES;
- HOUSING ASSISTANCE;
- EMERGENCY FINANCIAL ASSISTANCE;
- MEDICAL TRANSPORTATION; AND

Part VI **Supplemental Information** *(Continuation)*

- FOOD PANTRY.

IN JUNE 2014, WHIC COLLABORATED WITH THE WATERBURY HEALTH DEPARTMENT, GRACE BAPTIST CHURCH, AND OTHER AREA AIDS SERVICE ORGANIZATIONS, TO ORGANIZE THE WATERBURY AIDS WALK AND RAISE AWARENESS ABOUT HIV/AIDS TREATMENT AND TESTING IN WATERBURY. OVER 200 RESIDENTS PARTICIPATED IN THE EVENT.

PART VI, LINE 6:

N/A

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CT

PART VI, LINE 5 (CONTINUED):

RESHAPING HIV TESTING STATEWIDE: SINCE 2008, PATIENTS VISITING WATERBURY HOSPITAL'S EMERGENCY DEPARTMENT ARE OFFERED FREE HIV SCREENING WHILE WAITING TO BE EVALUATED OR TREATED FOR OTHER SYMPTOMS. IN ORDER TO OPTIMIZE THE NUMBER OF PEOPLE SCREENED FOR HIV, THE EMERGENCY DEPARTMENT'S PROGRAM USES AN OPT-OUT APPROACH. THE PROGRAM HAS SUCCESSFULLY SERVED AS A MODEL FOR OTHER HEALTHCARE INSTITUTIONS ACROSS THE STATE. THANKS, IN PART, TO WHIC'S LEADERSHIP, THE STATE OF CONNECTICUT NO LONGER LEGALLY REQUIRES PROVIDERS TO HAVE A SEPARATE CONSENT FORM FOR HIV TESTING.

ENGAGING PATIENTS: IN 2009, THE WHIC ESTABLISHED ITS PEER ADVOCATE PROGRAM. THREE PATIENTS FROM THE CLINIC SERVE AS THE PEER ADVOCATES,

Part VI Supplemental Information *(Continuation)*

WHO WORK WITH CLIENTS AT THE CLINIC AND USE A SOCIAL NETWORKS STRATEGY TO BRING DIFFICULT-TO-REACH CLIENTS IN FOR TESTING AND/OR CARE; THEY HAVE TRAVELED TO HIGH-RISK NEIGHBORHOODS ON THE WATERBURY HEALTH DEPARTMENT'S COMMUNITY HEALTH VAN TO OFFER COUNSELING AND TESTING AND HAVE PARTICIPATED IN AIDS AWARENESS DAYS TO FACILITATE THE LINKAGE OF NEWLY DIAGNOSED PATIENTS TO PRIMARY CARE. PEER ADVOCATES PARTICIPATE IN THE WHIC'S CARE TEAM AND CONTINUUM MEETINGS TO KEEP PROVIDERS AND LOCAL PARTNERS AWARE OF THE PATIENTS' ACTIVITIES AND NEEDS.

THIS YEAR ONE PEER ADVOCATE PARTICIPATED IN THE WATERBURY PARENT LEADERSHIP TRAINING INSTITUTE, COMPLETING A COMMUNITY PROJECT, "JOSE'S HAVEN," TO PROVIDE SUPPORT SERVICES, ENROLL CLIENTS IN INDIVIDUAL PHOTO DIARY PROJECTS, AND ENCOURAGE VOLUNTEERISM.

THE WHIC OFFERS ITS PATIENTS NATIONALLY-RECOGNIZED PEER AND SUPPORT PROGRAMS, INCLUDING ITS PROJECT PHOTOGRAPHY, WHICH WAS ESTABLISHED IN 2007 TO ENCOURAGE NON-COMPLIANT HIV/AIDS PATIENTS IN THE GREATER WATERBURY AREA TO BECOME MORE PROACTIVE IN THE SELF-MANAGEMENT OF THEIR DISEASE. PROJECT PHOTOGRAPHY HAS POSITIVELY TRANSFORMED ITS PARTICIPANT'S SELF-ESTEEM AND CONFIDENCE. PATIENT PROJECTS HAVE INCLUDED: (1) ENROLLING IN PHOTOGRAPHY CLASSES AT NAUGATUCK VALLEY COMMUNITY COLLEGE, (2) TAKING FIELD TRIPS, (3) DONATING FRAMED PHOTOGRAPHS TO THE HOSPITAL'S ANNUAL FUNDRAISING GALA AND PATIENT FLOORS, (4) PRODUCING HOLIDAY GREETING CARDS FOR THE ID CLINIC, (5) CREATING TEAM PORTRAITS AT THE HOSPITAL'S FUNDRAISING GOLF TOURNAMENT, AND (6) MOUNTING PHOTOGRAPHY EXHIBITS AT THE HOSPITAL, BARNES & NOBLE BOOKSTORE, AND SILAS BRONSON LIBRARY IN WATERBURY.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

▶ **Information about Schedule J (Form 990) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE WATERBURY HOSPITAL

Employer identification number

06-0665979

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2	X	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) DARLENE STROMSTAD	(i)	525,286.	51,500.	0.	82,650.	10,714.	670,150.	0.
PRESIDENT/TREASURER	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) DR. HENRY BORKOWSKI	(i)	750,082.	0.	0.	25,150.	12,310.	787,542.	0.
DIRECTOR / CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) DAVID J. PIZZUTO, MD	(i)	142,625.	31,159.	0.	5,202.	3,229.	182,215.	0.
DIRECTOR / VP MEDICAL SERVICES	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) SANDRA A. IADAROLA	(i)	204,007.	46,880.	0.	7,524.	9,167.	267,578.	0.
CHIEF NURSING OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DIANE M. WOOLLEY	(i)	180,957.	53,398.	0.	7,261.	17,430.	259,046.	0.
VP HUMAN RESOURCES	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) MICHAEL J. CEMENO	(i)	287,438.	66,805.	0.	7,650.	14,854.	376,747.	0.
CHIEF INFORMATION OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) THOMAS M. BURKE	(i)	173,802.	14,246.	0.	1,148.	15,895.	205,091.	0.
VICE PRESIDENT OPERATIONS	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) EHSAN ANSARI	(i)	876,277.	0.	0.	25,150.	16,697.	918,124.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) KEVIN KETT	(i)	861,837.	0.	0.	25,150.	16,697.	903,684.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) JOSEPH MORLEY	(i)	884,876.	0.	0.	25,150.	16,697.	926,723.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) MARK RUGGIERO	(i)	763,998.	0.	0.	25,150.	16,220.	805,368.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) STEPHEN WIDMAN	(i)	783,391.	0.	0.	25,150.	16,697.	825,238.	0.
CAGW - CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 4B:

DARLENE STROMSTAD'S SERP CONTRIBUTION: $75,000

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions. ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990

OMB No. 1545-0047
2013
Open to Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I Bond Issues SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	CONNECTICUT HEALTH & EDUCATIONAL FACILITIES A	06-0806186	NONE	12/22/10	25918000.	REFINANCE/RETIRE EXISTING BONDS &		X	X			X
B												
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	19,435,000.			
2	Amount of bonds legally defeased	19,435,000.			
3	Total proceeds of issue	25,918,000.			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	403,696.			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	7,876,000.			
11	Other spent proceeds	18,042,000.			
12	Other unspent proceeds				
13	Year of substantial completion	2013			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X						
15	Were the bonds issued as part of an advance refunding issue?		X						
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X						

Part III Private Business Use *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X						
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	%		%		%		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6 Total of lines 4 and 5	%		%		%		%	
7 Does the bond issue meet the private security or payment test?		X						
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X							

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?	X							
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?								
b Exception to rebate?								
c No rebate due?								
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?	X							
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X							
b Name of provider	RBS CITIZEN'S N.A.							
c Term of hedge	10.0000000							
d Was the hedge superintegrated?		X						
e Was the hedge terminated?		X						

Part IV **Arbitrage** *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X						
7 Has the organization established written procedures to monitor the requirements of section 148?	X							

Part V **Procedures To Undertake Corrective Action**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X							

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: CONNECTICUT HEALTH & EDUCATIONAL FACILITIES AUTHORITY
(F) DESCRIPTION OF PURPOSE:
REFINANCE/RETIRE EXISTING BONDS & FINANCE NEW MONEY FOR CAPITAL IMPROVEMENT

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization

THE WATERBURY HOSPITAL

Employer identification number

06-0665979

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 **(a)** Name of disqualified person	**(b)** Relationship between disqualified person and organization	**(c)** Description of transaction	**(d)** Corrected? Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	**(b)** Relationship with organization	**(c)** Purpose of loan	**(d)** Loan to or from the organization? To	From	**(e)** Original principal amount	**(f)** Balance due	**(g)** In default? Yes	No	**(h)** Approved by board or committee? Yes	No	**(i)** Written agreement? Yes	No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of assistance	**(d)** Type of assistance	**(e)** Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
DR. NEIL PETERSEN	TRUSTEE	56,250.	STIPEND FOR		X
CARL B. SHERTER	TRUSTEE	18,750.	STIPEND FOR		X
DR. NEIL PETERSEN	TRUSTEE	745,300.	DR. NEIL PE		X
DR. HENRY BORKOWSKI	TRUSTEE	138,880.	RENT FOR CA		X

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: DR. NEIL PETERSEN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

TRUSTEE

(C) AMOUNT OF TRANSACTION $ 56,250.

(D) DESCRIPTION OF TRANSACTION: STIPEND FOR SERVING AS CHIEF OF STAFF

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: CARL B. SHERTER

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

TRUSTEE

(C) AMOUNT OF TRANSACTION $ 18,750.

(D) DESCRIPTION OF TRANSACTION: STIPEND FOR SERVING AS CHIEF OF STAFF

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: DR. NEIL PETERSEN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

TRUSTEE

(C) AMOUNT OF TRANSACTION $ 745,300.

(D) DESCRIPTION OF TRANSACTION: DR. NEIL PETERSEN IS AN EMPLOYEE OF

Part V **Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

WATERBURY ANESTHESIOLOGY ASSOCIATES, WHICH PROVIDED ANESTHESIA SERVICES FOR THE WATERBURY HOSPITAL.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: DR. HENRY BORKOWSKI

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: TRUSTEE

(C) AMOUNT OF TRANSACTION $ 138,880.

(D) DESCRIPTION OF TRANSACTION: RENT FOR CARDIOLOGY ASSOCIATES OF GREATER WATERBURY, LLC OFFICE SPACE

(E) SHARING OF ORGANIZATION REVENUES? = NO

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

FAMILY OF PROFESSIONALS AND SERVICES.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS (CONTINUED):

TOTAL COMMUNITY BENEFITS FOR FY 2014 BY CATEGORY:

A. COMMUNITY HEALTH IMPROVEMENT SERVICES & COMMUNITY BENEFIT OPERATIONS

BENEFIT: $8,848,738

PERSONS SERVED: 25,237

- COMMUNITY HEALTH EDUCATION
- COMMUNITY-BASED CLINICAL SERVICES
- HEALTH CARE SUPPORT SERVICES

B. HEALTH PROFESSIONS EDUCATION

BENEFIT: $9,670,648

PERSONS SERVED: 1,689

- PHYSICIANS/MEDICAL STUDENTS
- NURSES/NURSING STUDENTS
- OTHER HEALTH PROFESSIONS EDUCATION
- SCHOLARSHIPS/FUNDING FOR PROFESSIONAL EDUCATION
- OTHER

D. RESEARCH

BENEFIT: $5,580

PERSONS SERVED: 17

- CLINICAL RESEARCH

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- COMMUNITY HEALTH RESEARCH

E. FINANCIAL AND IN-KIND CONTRIBUTIONS

BENEFIT: $108,982

PERSONS SERVED: 112,275

- CASH DONATIONS

- IN-KIND DONATIONS

F. COMMUNITY BUILDING ACTIVITIES

BENEFIT: $274,171

PERSONS SERVED: 12,813

- COMMUNITY SUPPORT

- ENVIRONMENTAL IMPROVEMENTS

- LEADERSHIP DEVELOPMENT/TRAINING COMMUNITY MEMBERS/ YOUTH PIPELINE

- COALITION BUILDING

- OTHER

G. COMMUNITY BENEFIT OPERATIONS

BENEFIT: $5,012

PERSONS SERVED: N/A

- DEDICATED STAFF

SUBTOTAL FOR COMMUNITY BENEFITS: $18,913,131

SUBTOTAL FOR PERSONS SERVED: 152,031

TRADITIONAL CHARITY CARE COSTS

- FREE CARE: $818,261

- BAD DEBT: $517,687

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- UNPAID MEDICAID COSTS: $7,919,998

- UNPAID MEDICARE COSTS: $7,750,927

SUBTOTAL FOR CHARITY CARE COSTS BENEFIT: $17,006,873

TOTAL BENEFIT - FY 2014: $35,920,004

CATEGORY A: COMMUNITY HEALTH IMPROVEMENT SERVICES

TOTAL BENEFIT: $8,848,738

TOTAL PERSONS SERVED: 25,237

REALIZING THE DIVERSE NEEDS OF RESIDENTS IN OUR COMMUNITY, WATERBURY HOSPITAL REMAINS DEDICATED TO PROVIDING COMPREHENSIVE HEALTH SERVICES TO ENSURE EVERY INDIVIDUAL HAS ACCESS TO APPROPRIATE, QUALITY HEALTHCARE.

DURING 2014, WATERBURY HOSPITAL'S SPECTRUM OF SERVICES CONTINUED TO HAVE A POSITIVE IMPACT ON THE WELFARE OF WATERBURY'S CITIZENS. TO REMAIN CONSISTENT WITH WATERBURY HOSPITAL'S MISSION, MANY OF OUR SERVICES ARE TARGETED FOR VULNERABLE MEMBERS OF OUR COMMUNITY, INCLUDING THOSE WHO ARE UNINSURED OR UNDERINSURED.

KEY PROGRAMS:

WATERBURY HEALTH ACCESS PROGRAM

WATERBURY HOSPITAL IS AWARE OF THE ECONOMIC NEEDS MANY PATIENTS IN OUR COMMUNITY, AND, AS A RESULT, WE REMAIN COMMITTED TO THE WATERBURY HEALTH ACCESS PROGRAM. FOUNDED IN 2003 AS A PARTNERSHIP BETWEEN

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WATERBURY HOSPITAL, ST. MARY'S HOSPITAL, STAYWELL HEALTH CENTER (FQHC), AND THE WATERBURY HEALTH DEPARTMENT, THE WATERBURY HEALTH ACCESS PROGRAM IMPROVES ACCESS TO HIGH-QUALITY MEDICAL CARE BY PROVIDING COMPREHENSIVE CASE MANAGEMENT, PHARMACY ASSISTANCE, AND ACCESS TO PRIMARY AND SUB-SPECIALTY MEDICAL CARE FOR THE UNINSURED AND UNDERINSURED RESIDENTS OF THE GREATER WATERBURY REGION. DURING FY 2014, THE WATERBURY HEALTH ACCESS PROGRAM HAD OVER 4,370 ACTIVE CLIENTS. ADDITIONALLY, WATERBURY HOSPITAL PROVIDED $402,864 WORTH OF DONATED SERVICES TO WHAP'S PATIENTS.

BEHAVIORAL HEALTH - WATERBURY HOSPITAL'S CENTER FOR BEHAVIORAL HEALTH IS ONE OF THE REGION'S LARGEST SERVICE PROVIDERS OFFERING A FULL CONTINUUM OF CARE FOR CHILDREN, ADOLESCENTS AND ADULTS. OUR SERVICES ALSO OUTREACH TO THE COMMUNITY THROUGH REGULAR PARTICIPATION IN HEALTH FAIRS, ELECTED MEMBERSHIP IN THE NORTHWEST REGIONAL MENTAL HEALTH BOARD, AS A HOST SITE TO NUMEROUS TWELVE-STEP MEETINGS AND THE PROVISION OF CASE MANAGEMENT AS WELL AS ACUTE SERVICES TO THE HOMELESS WITHIN THE CITY OF WATERBURY. BEHAVIORAL HEALTH CLINICIANS CAN ENGAGE CLIENTS TO HELP FACILITATE THEIR ENTRANCE INTO TREATMENT. WE PROVIDE PHONE SUPPORT, REFERRALS AND TRIAGING TEN HOURS A DAY SEVEN DAYS A WEEK. WITHIN OUR CRISIS CENTER WE OFFER SHORT TERM SERVICES TO HELP INDIVIDUALS OBTAIN MORE PERMANENT TREATMENT THAT BEST MEETS THEIR NEEDS. FOR INDIVIDUALS EXPERIENCING ACUTE SYMPTOMS WE OFFER INPATIENT TREATMENT TO ADOLESCENTS AGED 12 AND UP AS WELL AS ADULT SERVICES. OUR EFFORTS ARE AIMED AT PROMOTING THE BENEFITS OF CLINICAL TREATMENT AS WELL AS POSITIVE LIFESTYLE CHOICES. EVERY EFFORT IS MADE TO EDUCATE CLIENTS, THEIR FAMILIES AND THE COMMUNITY ABOUT MENTAL ILLNESS AND THE IMPACT TREATMENT CAN HAVE ON ONE'S ILLNESS. THE ULTIMATE GOAL IS TO

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HELP PEOPLE FEEL BETTER, REDUCE OR RESOLVE SYMPTOMS AND TO MINIMIZE THE STIGMA OF MENTAL ILLNESS.

BE WELL BUS - IN ORDER TO ENSURE THAT PATIENTS HAVE ACCESS TO MEDICAL APPOINTMENTS, AT THE HOSPITAL AND AT LOCAL PHYSICIANS' OFFICES, WATERBURY HOSPITAL'S BE WELL BUS PROVIDES TRANSPORTATION SERVICES TO PATIENTS FROM WATERBURY AND ELEVEN OF ITS SURROUNDING TOWNS. DURING FY 2014, THE BE WELL BUS'S HOURS OF OPERATION ARE FROM 6:00 AM TO 6:00 PM MONDAY - FRIDAY. THE PROGRAM OFFERED TRANSPORTS TO AND FROM MEDICAL APPOINTMENTS. WATERBURY HOSPITAL HAS CONTRACTED WITH A TRANSPORTATION PROVIDE TO OFFER THE BUS SERVICE, AND AREA PROVIDERS PAY A SMALL FEE TO PARTICIPATE. COMMUNITIES SERVED INCLUDE: WATERBURY, WATERTOWN, THOMASTON, SOUTHBURY, MIDDLEBURY, NAUGATUCK, WOLCOTT, AND BEACON FALLS IN ADDITION TO WATERBURY HOSPITAL. THIS PROGRAM CURRENTLY HAS 13 PARTICIPATING DEPARTMENTS WHICH INCLUDE 59 PRACTICING PHYSICIANS AND SPECIALISTS.

HEART CENTER OF GREATER WATERBURY - FORMED IN COLLABORATION WITH SAINT MARY'S HOSPITAL, THE HEART CENTER OF GREATER WATERBURY PROVIDES DIVERSE MEDICAL SUPPORT INITIATIVES TO HELP EDUCATE RESIDENTS IN THE GREATER WATERBURY COMMUNITY ABOUT PERTINENT HEALTH AND WELLNESS ISSUES. THIS PAST YEAR, THE HEART CENTER CONDUCTED A SERIES OF HEALTH FAIRS AND VARIOUS HEALTH AND WELLNESS EDUCATION SESSIONS, INCLUDING "HEALTH SCREENINGS," WHICH PROVIDES PATIENTS WITH COMPLIMENTARY BLOOD PRESSURE SCREENINGS AND HEALTH AWARENESS EDUCATION. THROUGH COLLABORATIVE EFFORT, THE HEART CENTER OF GREATER WATERBURY AND SAINT MARY'S HOSPITAL DEVOTED A TOTAL OF 28 HOURS TO THE SCREENING PROCESS. A NEW PROGRAM CALLED "SMOKING CESSATION" WAS ALSO DEVELOPED DURING THE FISCAL YEAR.

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THE SERIES HELPS OUR RESIDENTS KICK THE HABIT.

FAMILY BIRTHING CENTER - PROVIDING A CHILD-CENTERED FOCUS, WATERBURY HOSPITAL'S FAMILY BIRTHING CENTER OFFERS EXPECTANT PARENTS A VARIETY OF CLASSES INCLUDING: BREAST FEEDING, CHILDBIRTH WEEKEND WORKSHOP, AND CHILDBIRTH PREPARATION, WHICH INCLUDES LAMAZE IN ADDITION TO EXERCISING BREATHING AND RELAXATION TECHNIQUES. THE DEPARTMENT IS EXPECTING THE RETURN OF THE INFANT CARE CLASS BY THE END OF FY 2015. THE FAMILY BIRTHING CENTER ALSO SUGGESTED PLANS OF RESTRUCTURING THE WEBSITE TO BE MORE USER FRIENDLY AND ENGAGING.

THANK GOD I'M FEMALE - FOR THE PAST 20 YEARS, WATERBURY HOSPITAL'S "THANK GOD I'M FEMALE" HAS SERVED AS AN ANNUAL WOMEN'S WELLNESS FORUM THAT FEATURES 40 EDUCATIONAL BOOTHS AND HEALTH-RELATED GIVEAWAYS. THE ULTIMATE GOAL OF THE FORUM IS TO EDUCATE ATTENDEES ABOUT STRESS, MENTAL WELL-BEING, HEART HEALTH, DIET, OSTEOPOROSIS AND BONE HEALTH, CHANGE OF LIFE, AND MORE. IN 2014, OVER 500 AREA RESIDENTS ATTENDED THE EVENT.

EVERGREEN 50 CLUB - WATERBURY HOSPITAL'S EVERGREEN 50 CLUB IS AN ORGANIZATION COMPRISED OF OVER 15,000 MEMBERS OVER THE AGE OF 50. THE CLUB OFFERS WELLNESS PROGRAMMING, MEDICARE COUNSELING, AND HEALTH EDUCATION PRESENTATIONS ON A VARIETY OF TOPICS ARE PRESENTED BY HEALTH CARE PROFESSIONALS. PRESENTATION TOPICS INCLUDE: HOLISTIC HEALTH, VARICOSE VEIN TREATMENT, HEART DISEASE, SUMMER SKIN CARE, WEIGHT LOSS, BLOOD PRESSURE, BLADDER SCREENINGS, JOINT CARE AND REPLACEMENT, AND RESOLVING ADVERSE OUTCOMES WITH PATIENTS AND FAMILIES. ANNUALLY, THE EVERGREEN 50 CLUB HOSTS A HEALTH FAIR FOR ITS MEMBERS, WHICH PROVIDES FREE FLU SHOTS AND HEALTHCARE SCREENINGS.

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WATERBURY HOSPITAL INFECTIOUS DISEASE CLINIC (WHIC) -

CURRENT SERVICES: THE WHIC OFFERS A COMPREHENSIVE "ONE-STOP SHOPPING" MODEL THAT PROVIDES PATIENTS WITH ON-SITE PRIMARY AND SPECIALTY SERVICES, MEDICAL CASE MANAGEMENT, INDIVIDUALIZED MEDICATION ADHERENCE SERVICES, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, NUTRITION COUNSELING, INDIVIDUALIZED HIV EDUCATION, LABORATORY TESTING, AND RADIOLOGY SERVICES. WHIC'S PROVIDERS INCLUDE THREE BOARD-CERTIFIED/BOARD-ELIGIBLE INFECTIOUS DISEASE SPECIALISTS AS WELL AS AN ADVANCED PRACTITIONER NURSE AND A REGISTERED DIETICIAN, ALL WITH EXPERTISE IN THE MANAGEMENT OF PATIENTS WITH HIV/AIDS. IN FY 2014, WHIC SERVED AROUND 500 PEOPLE LIVING WITH HIV/AIDS (PLWHA).

WHIC'S STAFF MEMBERS ACTIVELY PARTICIPATE IN STATEWIDE AND AREA COLLABORATIVE, SUCH AS THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC) AND THE RYAN WHITE PART A PLANNING COUNCIL, AND WHIC FACILITATES THE GREATER WATERBURY HIV CONSORTIUM. WHIC HAS A VERY ACTIVE CONSUMER ADVISORY GROUP (CAG), WHICH ORGANIZES SOCIAL AND TESTING EVENTS FOR THE COMMUNITY AND FACILITATES THE WATERBURY HOSPITAL PHOTOGRAPHY GROUP.

FORGING COMMUNITY PARTNERSHIPS: SINCE 2009, THE WHIC HAS SERVED AS THE LEAD AGENCY FOR RYAN WHITE PART A FEDERAL FUNDING REGION 2 OF THE NEW HAVEN/FAIRFIELD ELIGIBLE METROPOLITAN AREA. THE WHIC WAS CHOSEN AS LEAD AGENCY BY THE CONSENSUS OF OTHER LOCAL RYAN WHITE PART A AGENCIES DUE TO ITS EXPERTISE IN PATIENT CARE AND FISCAL MANAGEMENT. AS THE LEAD AGENCY, THE WHIC HAS FORMED LONGSTANDING PARTNERSHIPS WITH STAYWELL HEALTH CENTER, INC., NEW OPPORTUNITIES, INC., RECOVERY NETWORK OF PROGRAMS, INC., AND CONNECTICUT COUNSELING CENTERS, INC., ALL OF WHOM

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WORK ALONGSIDE THE WHIC TO PROVIDE PATIENTS IN THE REGION WITH:

- PRIMARY HIV CARE

- MEDICAL CASE MANAGEMENT

- ORAL HEALTH CARE

- INPATIENT AND OUTPATIENT SUBSTANCE ABUSE TREATMENT

- HEALTH INSURANCE ASSISTANCE

- MENTAL HEALTH

- EARLY INTERVENTION SERVICES

- HOUSING ASSISTANCE

- EMERGENCY FINANCIAL ASSISTANCE

- MEDICAL TRANSPORTATION

- FOOD PANTRY

IN JUNE 2014, WHIC COLLABORATED WITH THE WATERBURY HEALTH DEPARTMENT, GRACE BAPTIST CHURCH, AND OTHER AREA AIDS SERVICE ORGANIZATIONS, TO ORGANIZE THE WATERBURY AIDS WALK AND RAISE AWARENESS ABOUT HIV/AIDS TREATMENT AND TESTING IN WATERBURY. OVER 200 RESIDENTS PARTICIPATED IN THE EVENT.

RESHAPING HIV TESTING STATEWIDE: SINCE 2008, WATERBURY HOSPITAL (WH) HAS BEEN AT THE FOREFRONT OF DEVELOPING AND IMPLEMENTING SYSTEMS TO ROUTINIZE HIV SCREENING IN ORDER TO IDENTIFY INDIVIDUALS UNAWARE OF THEIR DIAGNOSIS. SINCE 2012, PATIENTS VISITING WH'S EMERGENCY DEPARTMENT RECEIVED WRITTEN NOTIFICATION THAT THEY MAY BE SCREENED FOR HIV UNLESS THEY ELECT TO OPT-OUT. IN ADDITION, ALLIANCE MEDICAL GROUP OFFICES HAVE BEEN PROVIDED TOOLS THAT INCORPORATE ROUTINE HIV SCREENING INTO THEIR PRACTICE. IN THE NEAR FUTURE, WH PLANS TO LAUNCH AN AUTOMATED SYSTEM TO ENSURE THAT ALL PATIENTS VISITING THE WH CAMPUS ARE

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AWARE OF THEIR HIV STATUS. NEWLY DIAGNOSED INDIVIDUALS WILL ALSO BE FAMILIARIZED WITH AVAILABLE TREATMENT OPTIONS AND CARE AT THE WATERBURY HOSPITAL INFECTIOUS DISEASE AND TRAVEL CLINIC.

ENGAGING PATIENTS: IN 2009, THE WHIC ESTABLISHED ITS PEER ADVOCATE PROGRAM. THREE PATIENTS FROM THE CLINIC SERVE AS THE PEER ADVOCATES, WHO WORK WITH CLIENTS AT THE CLINIC AND USE A SOCIAL NETWORKS STRATEGY TO BRING DIFFICULT-TO-REACH CLIENTS IN FOR TESTING AND/OR CARE; THEY HAVE TRAVELED TO HIGH-RISK NEIGHBORHOODS ON THE WATERBURY HEALTH DEPARTMENT'S COMMUNITY HEALTH VAN TO OFFER COUNSELING AND TESTING AND HAVE PARTICIPATED IN AIDS AWARENESS DAYS TO FACILITATE THE LINKAGE OF NEWLY DIAGNOSED PATIENTS TO PRIMARY CARE. PEER ADVOCATES PARTICIPATE IN THE WHIC'S CARE TEAM AND CONTINUUM MEETINGS TO KEEP PROVIDERS AND LOCAL PARTNERS AWARE OF THE PATIENTS' ACTIVITIES AND NEEDS.

THE WHIC OFFERS ITS PATIENTS NATIONALLY-RECOGNIZED PEER AND SUPPORT PROGRAMS, INCLUDING ITS PROJECT PHOTOGRAPHY, WHICH WAS ESTABLISHED IN 2007 TO ENCOURAGE NON-COMPLIANT HIV/AIDS PATIENTS IN THE GREATER WATERBURY AREA TO BECOME MORE PROACTIVE IN THE SELF-MANAGEMENT OF THEIR DISEASE. PROJECT PHOTOGRAPHY HAS POSITIVELY TRANSFORMED ITS PARTICIPANT'S SELF-ESTEEM AND CONFIDENCE. PATIENT PROJECTS HAVE INCLUDED: (1) ENROLLING IN PHOTOGRAPHY CLASSES AT NAUGATUCK VALLEY COMMUNITY COLLEGE, (2) TAKING FIELD TRIPS TO BOSTON AND RHODE ISLAND, (3) DONATING FRAMED PHOTOGRAPHS TO THE HOSPITAL'S ANNUAL FUNDRAISING GALA, (4) PRODUCING HOLIDAY GREETING CARDS FOR THE ID CLINIC, (5) CREATING TEAM PORTRAITS AT THE HOSPITAL'S FUNDRAISING GOLF TOURNAMENT, AND (6) CONSTRUCTING PHOTOGRAPHY EXHIBITS AT THE HOSPITAL ON THE FIRST FLOOR AND IN THE POMEROY; ACCOMPLISHED BY 9 PHOTOGRAPHY STUDENTS FROM

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THE PEACH PROGRAM AND THE SUMMER BRIDGE PROGRAM.

THE FOOD FOR LIFE PROGRAM IS AN INNOVATIVE PROGRAM RECENTLY ESTABLISHED BY WHIC IN COLLABORATION WITH THE WATERBURY YMCA. THIS PROVIDES ACCESS TO FRESH FRUITS AND VEGETABLES AND ENROLLMENT IN EXERCISE PROGRAMS TO QUALIFIED PATIENTS AT NO COST. THE WHIC OFFERS A FITNESS CLASS MONTHLY AND YOGA MONTHLY AS WELL TO PATIENTS, AND NUTRITION, HEALTH, WELLNESS SUPPORT GROUP BIWEEKLY TO ENGAGE IN POSITIVE ACTIVITIES.

CATEGORY B: HEALTH PROFESSIONS EDUCATION

TOTAL BENEFIT: $9,670,648

TOTAL PERSONS SERVED: 1,689

SINCE IT FIRST AFFILIATED WITH THE YALE UNIVERSITY SCHOOL OF MEDICINE IN 1973, WATERBURY HOSPITAL HAS SERVED AS THE CLINICAL TRAINING SITE FOR THOUSANDS OF MEDICAL PROFESSIONALS IN TRAINING. DURING FY 2014, STUDENTS COMPLETED CLINICAL ROTATIONS, INTERNSHIPS, AND SHADOWING EXPERIENCES AT WATERBURY HOSPITAL.

KEY PROGRAMS:

WATERBURY HOSPITAL INTERNAL MEDICINE RESIDENCY PROGRAM -

IN 2014, TWENTY-FOUR RESIDENTS WERE ENROLLED IN THIS PROGRAM. THE RESIDENCY PROGRAM IS SPONSORED BY YALE-NEW HAVEN HOSPITAL AND AFFILIATED WITH YALE UNIVERSITY.

ACTIVITIES INCLUDE:

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- PARTICIPATION IN RESEARCH DAYS AT YALE AND WATERBURY HOSPITAL/SAINT MARY'S HOSPITAL

- HOME AND OFFICE VISITS FOR CLINIC PATIENTS

- EDUCATIONAL SEMINARS HELD AT WATERBURY HOSPITAL AND YALE UNIVERSITY.

AT WATERBURY HOSPITAL, WE SEEK TO TRAIN PHYSICIANS WHO DESIRE A GENERALIST BACKGROUND TO THEIR CAREERS IN MEDICINE. THIS PROGRAM IS UNIQUE IN THAT IT PROVIDES THE MEDICAL RESIDENTS THE OPPORTUNITY TO WORK EACH YEAR AT WATERBURY HOSPITAL AND OUTPATIENT PRACTICE SITES THAT INCLUDE PRIVATE PRACTICE OFFICES AND COMMUNITY HEALTH CENTERS. OUR GRADUATES ARE HIGHLY SOUGHT AFTER BY PRIVATE PRACTICE OFFICES, HOSPITALIST PROGRAMS, AND FELLOWSHIP PROGRAMS THROUGHOUT THE COUNTRY.

OTHER RESIDENCY PROGRAMS -

WATERBURY HOSPITAL ALSO HAS A SURGERY RESIDENCY PROGRAM. THE PROGRAM IS AFFILIATED WITH YALE UNIVERSITY, UNIVERSITY OF CONNECTICUT MEDICAL CENTER, AND QUINNIPIAC UNIVERSITY SCHOOL OF MEDICINE. TWELVE RESIDENTS WERE ENROLLED IN 2014. THIS PROGRAM PROVIDES A FULL SPECTRUM OF SURGICAL EXPERIENCES FOR THE HOSPITAL'S RESIDENTS. GENERAL SURGERY AND MEDICINE TRAINING PROGRAMS INCLUDES ACCESS TO GENERAL SURGERY, ENT, UROLOGY, PLASTICS, GYN, NEUROSURGERY AN ORTHOPEDIC CASES.

WATERBURY HOSPITAL HAS A PHARMACY RESIDENCY PROGRAM. TWO STUDENTS ARE ENROLLED IN THE PHARMACY RESIDENCY PROGRAM. WATERBURY HOSPITAL'S PGY-1 PROGRAM IS ACCREDITED BY THE AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS (ASHP). TWO RESIDENT POSITIONS WILL BE AVAILABLE EACH YEAR. THE MISSION OF THE PHARMACY RESIDENCY PROGRAM IS TO BE CLINICALLY

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FOCUSED AND TO SHARE RESPONSIBILITY FOR THE OPTIMAL OUTCOME OF PATIENT DRUG THERAPIES. 1-YEAR OF CONCENTRATED TRAINING IN ALL ASPECTS OF PHARMACY PRACTICE IS PROVIDED IN ADDITION TO LEARNING ACTIVITY ROTATIONS THAT ACCOMMODATE THE RESIDENT'S PREVIOUS EXPERIENCES AND CURRENT GOALS. ROTATIONS INCLUDED ARE:

- PHARMACY OPERATIONS (FOUR WEEKS)
- INTERNAL MEDICINE (EIGHT WEEKS)
- CRITICAL CARE (EIGHT WEEKS)
- EMERGENCY MEDICINE (SIX WEEKS)
- PSYCHIATRY (FOUR WEEKS)
- PHARMACY ADMINISTRATION (SIX WEEKS)
- PAIN MANAGEMENT (FOUR WEEKS)
- PHARMACY INFORMATICS (FOUR WEEKS)
- AMBULATORY CARE (LONGITUDINAL)

THIS PROGRAM SATISFIES THE ASHP PGY-1 REQUIRED OUTCOMES.

STUDENT NURSE INTERN PROGRAM (SNI) -

THE SNI PROGRAM IS AVAILABLE FOR NURSING STUDENTS ENTERING THEIR SENIOR YEAR. THE PROGRAM PROVIDES THESE STUDENT NURSES WITH SHADOWING OPPORTUNITIES SO THEY CAN APPLY THEIR CONTENT KNOWLEDGE TO AUTHENTIC PATIENT CARE SITUATIONS. STAFF RNS SERVE AS THE STUDENTS' MENTORS AS THE STUDENTS ACCOMPANY THEM ON THEIR MEDICAL ROUNDS. THE GOALS OF THE PROGRAM ARE: (1) TO PROVIDE THE STUDENT NURSES WITH THE KNOWLEDGE AND SKILLS NECESSARY TO PASS THE NCLEX EXAM AND (2) TO SOCIALIZE THE STUDENT NURSE IN AN ATTEMPT TO DECREASE THE STRESS OF ASSIMILATING INTO

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THE HOSPITAL'S WORK ENVIRONMENT, SHOULD THEY BE HIRED AS GRADUATE NURSES AT WATERBURY HOSPITAL.

PHYSICIAN'S ASSISTANT (PA) STUDENTS -

P.A. STUDENTS FROM QUINNIPIAC UNIVERSITY COMPLETED CLINICAL ROUNDS IN SEVERAL DEPARTMENTS AROUND THE HOSPITAL, INCLUDING THE OPERATING ROOM, EMERGENCY DEPARTMENT, BEHAVIORAL HEALTH, AND RADIOLOGY. THE EXPERIENCE IS DESIGNED FOR THE STUDENT TO LEARN TO APPLY THE KNOWLEDGE GAINED FROM DIDACTIC COURSE WORK IN MEDICINE, SURGERY, AND THE BASIC AND BEHAVIORAL SCIENCES INTO THE CLINICAL ARENA RESULTING IN THE ABILITY TO SUCCESSFULLY MANAGE PATIENTS IN A THOROUGH AND COMPREHENSIVE MANNER. THE PRIMARY GOAL OF CLINICAL ROTATIONS IS TO EXPOSE THE STUDENT TO PATIENTS OF ALL AGES, PATIENTS IN A VARIETY OF DIFFERENT SETTINGS, AND PATIENTS WITH A BROAD RANGE OF MEDICAL, SURGICAL, AND PSYCHOSOCIAL PROBLEMS.

THE P.A. STUDENTS PARTICIPATE IN:

- HISTORY TAKING
- EXAMINING THE PATIENT
- ASSISTING IN AND/OR PERFORMING DIAGNOSTIC TESTING
- ASSISTING IN AND/OR PERFORMING THERAPEUTIC TASKS
- ORAL PRESENTATIONS
- MEDICAL DOCUMENTATION OF THE PATIENT ENCOUNTER
- FORMULATING A DIFFERENTIAL DIAGNOSIS AND PROBLEM LIST
- FORMULATING A TREATMENT PLAN
- COUNSELING OF PATIENTS REGARDING MEDICATION, DIET, AND LIFESTYLE CHANGES SUCH AS SMOKING CESSATION, EXERCISE, AND WELL-BEING.

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

RADIOLOGY STUDENTS FROM NVCC -

THE NAUGATUCK VALLEY COMMUNITY COLLEGE (NVCC) RADIOLOGY STUDENTS ARE INVOLVED WITH MANY ACTIVITIES WHILE ASSIGNED TO WATERBURY HOSPITAL. UNDER THE SUPERVISION OF A NVCC CLINICAL INSTRUCTOR AND HOSPITAL RADIOLOGIC TECHNOLOGISTS, THE STUDENTS ARE ASSIGNED TO THE VARIOUS RADIOGRAPHIC SUITES AND MODALITIES. DURING THEIR ASSIGNMENT, STUDENTS ARE PERFORMING OR ASSISTING WITH RADIOGRAPHIC PROCEDURES, INCLUDING CHEST X-RAYS, SKELETAL EXAMS, FLUOROSCOPIC PROCEDURES, MOBILE X-RAYS IN THE VARIOUS PATIENT UNITS, AND SURGICAL CASES. THE STUDENTS ALSO INCREASE THE NUMBER OF INDIVIDUALS AVAILABLE IN THE DEPARTMENT TO ASSIST IN MOVING AND TRANSPORTING PATIENTS AS WELL AS CHAPERONING SENSITIVE EXAMS. IN ADDITION TO THE DIAGNOSTIC RADIOLOGY THE STUDENTS ARE ASSIGNED TO EXPERIENCES IN INTERVENTIONAL RADIOLOGY, CT, MRI, NUCLEAR MEDICINE, AND ULTRASOUND. STUDENTS WORK IN THESE MODALITIES UNDER THE DIRECT SUPERVISION OF THE HOSPITAL STAFF.

WATERBURY HOSPITAL'S AFFILIATION WITH NVCC AS A CLINICAL SITE FOR STUDENTS HAS MANY BENEFITS. PERHAPS THE SINGLE MOST IMPORTANT BENEFIT IS THE HOSPITAL HAS A CONTINUOUS STREAM OF POTENTIAL RADIOLOGY EMPLOYEES. STUDENTS ARE IN THE PROGRAM FOR 22 MONTHS AND IN THAT TIME BECOME VERY FAMILIAR WITH THE HOSPITAL EQUIPMENT, ROUTINES, PERSONAL, AND MISSION. THIS PROVIDES WATERBURY HOSPITAL WITH NEW EMPLOYEES WHO HAVE A STRONG SKILL SET AND PROVEN DEDICATION TO THE HOSPITAL COMMUNITY.

CATEGORY D: RESEARCH

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

TOTAL BENEFIT: $5,580

TOTAL PERSON SERVED: 17

DURING 2013-2014, WATERBURY HOSPITAL PARTICIPATED IN SEVERAL CLINICAL TRIALS THAT BENEFITED RESIDENTS IN GREATER WATERBURY. THESE TRIALS INCLUDED: THE BIOMARKERS STUDY, WHICH EXPLORED THE IDENTIFICATION OF BIOMARKERS FOR PREDICTION OF RESPONSE TO PREOPERATIVE CHEMORADIOTHERAPY IN PATIENTS WITH RECTAL CANCER; THE ROCKING CHAIR STUDY, WHICH INVESTIGATED ROCKING CHAIR SINGLE WAVE MOTION INTERVENTION FOR POST-SURGICAL PATIENT CARE; THE INFECTIVE ENDOCARDITIS STUDY RUN IN COLLABORATION WITH DUKE UNIVERSITY, WHICH ENROLLS PATIENTS EITHER DIAGNOSED OR PRESENTING SYMPTOMS OF INVECTIVE ENDOCARDITIS FOR A PROSPECTIVE DATA COLLECTION STUDY; AND THE FECAL TRANSPLANT STUDY, WHICH ENROLLS PATIENTS WITH RESISTANT CLOSTRIDIUM DIFFICILE COLITIS WHO HAVE HAD 2 OR MORE RELAPSES OF COLITIS IN SPITE OF ANTIBIOTIC THERAPY.

CATEGORY E: FINANCIAL & IN-KIND CONTRIBUTIONS

TOTAL BENEFIT: $108,982

TOTAL PERSONS SERVED: 112,275

WATERBURY HOSPITAL CONTINUES TO PROVIDE FINANCIAL AND IN-KIND CONTRIBUTIONS TO MEMBERS OF OUR COMMUNITY. FROM UNITED WAY DONATIONS FROM HOSPITAL EMPLOYEES TO FREE PARKING FOR PATIENTS, WATERBURY HOSPITAL PROVIDED $30,705.00 WORTH OF FINANCIAL AND IN-KIND SUPPORT DURING 2014. LOCAL AGENCIES RECEIVING DONATIONS INCLUDED:

- EASTER SEALS
- HOMELESS CONNECT
- MATTATUCK MUSEUM

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

- PALACE THEATER

- UNITED WAY OF GREATER WATERBURY

- VNA HEALTH AT HOME

- WATERBURY SYMPHONY ORCHESTRA

- WATERBURY REGIONAL CHAMBER

CATEGORY F: COMMUNITY BUILDING ACTIVITIES

TOTAL BENEFIT: $274,171

TOTAL PERSONS SERVED: 12,813

AS A LEADER IN THE DELIVERY OF HEALTHCARE SERVICES IN THE GREATER WATERBURY AREA, WATERBURY HOSPITAL (WH) IS COMMITTED TO STRENGTHENING THE WELFARE AND AWARENESS OF THE CITIZENS WITHIN ITS COMMUNITY. FROM STRENGTHENING THE CAREER PATHS OF WATERBURY AREA YOUTH; TO SUPPORTING THE UNINSURED AND UNDERINSURED THROUGH THE WATERBURY HEALTH ACCESS PROGRAM AND; PROVIDING TRANSPORT TO AND FROM MEDICAL APPOINTMENTS; WATERBURY HOSPITAL IS REMOVING THE BARRIERS TO QUALITY HEALTH CARE FOR ALL AND REMAINS FIRM IN ITS COMMITMENT TO A HEALTHIER, STRONGER, AND MORE PRODUCTIVE COMMUNITY.

KEY PROGRAMS:

YOUTH PIPELINE INITIATIVES:

THE WATERBURY HOSPITAL YOUTH PIPELINE INITIATIVES WERE ESTABLISHED IN 2001 AS A PARTNERSHIP BETWEEN WATERBURY HOSPITAL AND WATERBURY PUBLIC SCHOOLS. THE MISSION OF THE PROGRAM IS: "TO CLOSE THE ACHIEVEMENT GAP FOR MINORITY AND ECONOMICALLY DISADVANTAGED STUDENTS IN WATERBURY SO

THEY CAN MATRICULATE AND COMPETE NATIONALLY FOR PLACEMENT IN POST-SECONDARY EDUCATION PROGRAMS IN PREPARATION FOR HEALTH CAREERS". WATERBURY HOSPITAL IS COMMITTED TO ENHANCING AND ENRICHING THE ACADEMIC OPPORTUNITIES AND PERSONAL JOURNEYS OF OUR YOUTH, WHO ARE THE EMERGING WORKFORCE OF TOMORROW. TO THIS END, DURING 2014, WATERBURY HOSPITAL PROVIDED 129 STUDENTS AND PARENTS IN GREATER WATERBURY WITH UNIQUE EDUCATIONAL PROGRAMS THAT WILL ENHANCE THE OVERALL WELFARE OF OUR COMMUNITY.

THE WH YOUTH PIPELINE INITIATIVES HAD SIX FOCUS AREAS DURING FY 2014, INCLUDING:

- PARENT LEADERSHIP TRAINING INSTITUTE (PLTI) - IN 2014, SIX INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED WATERBURY'S PLTI, A 20-WEEK CURRICULUM TEACHING LEADERSHIP AND ADVOCACY SKILLS, AS WELL AS INDIVIDUAL COMMUNITY PROJECT PLANNING. PLTI'S CORE MISSION IS TO IMPART LEADERSHIP AND ADVOCACY SKILLS TO PARENTS WHILE SIMULTANEOUSLY EDUCATING THEM ABOUT VOLUNTEERISM, CIVIC LIFE, AND THE PROCESS BY WHICH STATE AND LOCAL GOVERNMENTS ENACT AND CHANGE LAWS. EACH PARTICIPANT COMPLETES AND IMPLEMENTS A COMMUNITY PROJECT; EXAMPLES OF PROJECTS FROM 2014 INCLUDE: A "JUJI'S SENSORY FRIENDLY FILMS" PROGRAM-TO CREATE A SAFE AND ACCEPTING ENVIRONMENT FOR CHILDREN ON THE AUTISM SPECTRUM TO ATTEND FILMS AT THE MOVIE THEATER ON A MONTHLY BASIS AND "PADRE LATINOS" - A SUPPORT GROUP FOR SINGLE FATHERS TO LEARN KNOWLEDGE AND INFORMATION THROUGH THE LIFE EXPERIENCES OF THEIR PEERS.

- PARENTS SUPPORTING EDUCATIONAL EXCELLENCE (PSEE) - IN 2014, SEVENTEEN INDIVIDUALS FROM GREATER WATERBURY SUCCESSFULLY COMPLETED

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

WATERBURY'S PSEE, A 12-WEEK CURRICULUM CO-CREATED BY THE CONNECTICUT CENTER FOR SCHOOL CHANGE AND THE CONNECTICUT COMMISSION ON CHILDREN FOR PARENTS (DEFINED BROADLY AS PARENTS, GUARDIANS, FAMILY MEMBERS AND GRANDPARENTS) TO INSTILL LEADERSHIP SKILLS IN EDUCATION AND TO FACILITATE PARTNERSHIPS BETWEEN SCHOOL STAFF AND PARENTS TO IMPROVE STUDENT LEARNING.

- UCONN PEOPLE EMPOWERING PEOPLE (PEP) OFFERED IN SPANISH AND ALBANIAN - BOTH FREE INAUGURAL PROGRAMS WERE HELD IN 2014. THE PROGRAMS INCLUDED A 10-WEEK PARENT LEADERSHIP AND ADVOCACY REGIMEN THROUGH WHICH 9 PARTICIPANTS SUCCESSFULLY COMPLETED THE ALBANIAN PORTION OF THE PEP COURSE AND 21 PARTICIPANTS COMPLETED THE SPANISH PORTION OF THE PEP COURSE. UCONN PEP IS A PERSONAL, FAMILY AND LEADERSHIP DEVELOPMENT PROGRAM WITH A STRONG COMMUNITY FOCUS. PEP IS DESIGNED TO BUILD ON THE UNIQUE STRENGTHS AND LIFE EXPERIENCES OF PARTICIPANTS AND EMPHASIZES THE CONNECTION BETWEEN INDIVIDUAL AND COMMUNITY ACTION. BOTH UCONN PEP PROGRAMS ARE SIGNIFICANT FOR TWO REASONS; IT WAS THE FIRST TIME THAT A UCONN PEP COURSE HAS BEEN OFFERED IN BOTH ALBANIAN AND SPANISH AT WATERBURY HOSPITAL. HOWEVER IT IS ALSO THE FIRST TIME AN ALBANIAN AND SPANISH PARENT LEADERSHIP PROGRAM IS OFFERED WITH IN THE STATE OF CONNECTICUT. PARTICIPANTS OF BOTH PROGRAMS WORK INDIVIDUALLY OR COLLABORATIVELY TO CREATE A COMMUNITY PROJECT WHICH IS COMPLETED AS THE CONCLUDING PORTION OF THE PROGRAM

- WH SUMMER BRIDGE PROGRAM - DURING THE SUMMER OF 2014, TWENTY-EIGHT STUDENTS FROM WATERBURY, GRADES 6-11, PARTICIPATED IN THE WH SUMMER BRIDGE PROGRAM. 100% OF MEALS WERE SECURED FOR THE PROGRAM FROM CITY OF WATERBURY SUMMER FOOD PROGRAM.

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

STUDENTS COMPLETED THE FOLLOWING MODULES:

- 12 HOURS OF MATH (PRE- ALGEBRA, ALGEBRA II, GEOMETRY AND CALCULUS) REVIEW SESSIONS

- 20 HOURS OF SAT WRITING AND VOCABULARY

- 18 HOURS OF PHOTOVOICE PROJECT, STUDENTS WERE INSTRUCTED ON PHOTOGRAPHY TECHNIQUES, COMPOSITION, AND EDITING USING ADOBE PHOTOSHOP SOFTWARE AND SLR CAMERAS

- 6 HOURS OF ESSAY WRITING

- 11 HOURS OF POETRY INSTRUCTION AND PARTICIPATION IN THE SECOND ANNUAL WH POETRY SLAM

- 8 HOURS OF JOB SHADOWING SESSIONS IN THE FOLLOWING DEPARTMENTS: NURSING, HEALTH INFORMATION MANAGEMENT, HUMAN RESOURCES, RESPIRATORY THERAPY, WATERBURY HEALTH ACCESS PROGRAM, MORRISON FOOD SERVICES & NUTRITION, FINANCE, INFECTIOUS DISEASES CLINIC, LAB, PHARMACY, CENTRAL SCHEDULING, PLANT ENGINEERING, HAROLD LEEVER REGIONAL CANCER CENTER, AMERICAN MEDICAL REPONSES, AND CLINICAL EDUCATION, WHICH INCLUDED PARTICIPATING IN CLASSES SPONSORED BY THE AMERICAN RED CROSS (CPR AND BABYSITTING).

- CPR & AMERICAN RED CROSS CERTIFIED BABYSITTING COURSE.

- 2 HOURS OF MS OFFICE COMPUTER SESSIONS

- 6 HOUR SCIENCE MODULE AT STONE ACADEMY

- 2 FULL-DAY FIELD TRIPS COMPLETED: ONE TO YALE UNIVERSITY FOR AN ADMISSIONS INFO SESSION AND CAMPUS TOUR AND ONE TO HAMMONASSET STATE PARK INCLUDING THREE EDUCATIONAL SESSIONS AT MEIGS POINT NATURE CENTER

- 2 HOURS OF COLLEGE ADMISSIONS PRESENTATIONS COMPLETED BY UCONN WATERBURY & NAUGATUCK VALLEY COMMUNITY COLLEGE

- 1 HOUR OF INDIVIDUAL ACADEMIC ADVISING

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

- 2 HOURS OF HR ORIENTATION & SOFT SKILLS TRAINING

- 10 HOURS OF SOCIAL DETERMINANTS OF HEALTH DOCUMENTARIES AND ACTIVE DISCUSSIONS WITH THE WATERBURY DEPARTMENT OF PUBLIC HEALTH

- PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) - SINCE ITS INCEPTION IN 2004, WATERBURY HOSPITAL'S PROVIDING EARLY ACQUAINTANCE WITH CAREERS IN HEALTHCARE (PEACH) PROGRAM HAS ENGAGED ADMINISTRATORS, TEACHERS, AND STUDENTS FROM MIDDLE SCHOOLS IN GREATER WATERBURY TO ADDRESS PROJECTED SHORTAGES OF HEALTHCARE WORKERS AND TO CLOSE THE ACHIEVEMENT GAP FOR STUDENTS IN WATERBURY PUBLIC SCHOOLS. THROUGH THE PEACH PROGRAM, STUDENTS ENGAGE WITH HEALTHCARE WORKERS IN A NON-EMERGENCY SETTING AND ARE INFORMED OF THE VARIETY OF HEALTHCARE CAREER OPPORTUNITIES AVAILABLE IN OUR COMMUNITY. ANNUALLY, WATERBURY HOSPITAL ALSO OFFERS ITS PEACH SPRING BREAK EXPLORATION CAMP, THIS YEAR 48 MIDDLE SCHOOL STUDENTS FROM WATERBURY TOOK PART IN: SHADOWING AND HANDS-ON LEARNING ACTIVITIES AT THE HOSPITAL; CPR CERTIFICATION; AND EDUCATIONAL SESSIONS AT THE MYSTIC AQUARIUM.

SUPPORT GROUPS - DURING 2014, WATERBURY HOSPITAL HOSTED SEVERAL SUPPORT GROUPS FOR ITS PATIENTS AND THEIR FAMILIES, INCLUDING:

- BEHAVIORAL HEALTH'S PARENT AND SIBLING SUPPORT GROUP, WHICH OFFERS EMOTIONAL ASSISTANCE TO FAMILIES WHO HAVE CHILDREN IN TREATMENT; AND

- ALCOHOLICS ANONYMOUS, SERVES OVER 4,000 PEOPLE ANNUALLY, MEETS WEEKLY THROUGHOUT THE YEAR, AND IS COORDINATED BY OUR BEHAVIORAL HEALTH DEPARTMENT.

FORM 990, PART VI, SECTION A, LINE 6:

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

GREATER WATERBURY HEALTH NETWORK, INC. IS SOLE MEMBER.

FORM 990, PART VI, SECTION A, LINE 7A:

GREATER WATERBURY HEALTH NETWORK, INC. ELECTS HOSPITAL BOARD.

FORM 990, PART VI, SECTION A, LINE 7B:

GREATER WATERBURY HEALTH NETWORK, INC. HAS RESERVED POWERS FOR HOSPITAL TRANSACTIONS.

FORM 990, PART VI, SECTION B, LINE 11:

THE FORM 990 IS REVIEWED AND APPROVED BY THE ORGANIZATION'S AUDIT COMMITTEE. A COPY OF THE FORM 990 IS THEN MADE AVAILABLE TO EACH BOARD MEMBER BEFORE IT IS FILED.

FORM 990, PART VI, SECTION B, LINE 12C:

THE HOSPITAL COMPLIANCE OFFICER REVIEWS ANNUALLY THE SUBMISSION OF POTENTIAL/ACTUAL CONFLICT DECLARATIONS. THEY ARE ALSO REVIEWED ANNUALLY AT THE BOARD'S COMPLIANCE AND ETHICS COMMITTEE MEETING AND RECOMMENDATIONS FOR ACTION ARE MADE TO THE FULL BOARD AS NECESSARY. ADDITIONALLY, RESPONSES ARE PROFILED, BY MEMBER, FOR EACH COMMITTEE OF THE BOARD/NETWORK, AND DISTRIBUTED AT EACH COMMITTEE MEETING AS A WAY TO PROMOTE TRANSPARENCY. THE COMMITTEE CHAIR AND MEMBERS SHARE RESPONSIBILITY IN IDENTIFYING AND MANAGING THESE DECLARED CONFLICTS OF INTEREST WHEN MAKING BUSINESS DECISIONS ON BEHALF OF THE HOSPITAL.

FORM 990, PART VI, SECTION B, LINE 15:

EXECUTIVE COMPENSATION IS UNDER THE PURVIEW OF THE BOARD OF TRUSTEES. THERE IS A COMPENSATION COMMITTEE AND THEY ALWAYS USE THE

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

SERVICES OF AN INDEPENDENT COMPENSATION CONSULTANT WHO USES NATIONAL, STATE AND REGIONAL COMPENSATION SURVEY DATA FOR SIMILAR TAX EXEMPT COMMUNITY HOSPITALS.

FORM 990, PART VI, SECTION C, LINE 19:

FINANCIAL RESULTS ARE MADE AVAILABLE IN THE ANNUAL REPORT TO THE COMMUNITY. GOVERNING DOCUMENTS AND THE CONFLICT OF INTEREST POLICY ARE AVAILABLE UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:

CONSULTING FEES:

PROGRAM SERVICE EXPENSES	377,502.
MANAGEMENT AND GENERAL EXPENSES	1,498,524.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,876,026.

PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	28,088,112.
MANAGEMENT AND GENERAL EXPENSES	9,898,230.
FUNDRAISING EXPENSES	1,599.
TOTAL EXPENSES	37,987,941.

PROFESSIONAL MEDICAL FEES:

PROGRAM SERVICE EXPENSES	10,342,344.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	10,342,344.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	50,206,311.

Name of the organization: THE WATERBURY HOSPITAL

Employer identification number: 06-0665979

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

INCREASE IN FAIR VALUE OF FUNDS HELD IN TRUST BY OTHERS	1,157,722.
ALLIANCE SUBSIDY	-8,152,669.
PENSION LIABILITY ADJUSTMENT	-841,605.
INTEREST RATE SWAP ADJUSTMENT	217,110.
INCOME FROM WATERBURY GASTROENTEROLGY	-62,801.
TOTAL TO FORM 990, PART XI, LINE 9	-7,682,243.

FORM 990, PART XII, LINE 2C:

THE AUDIT COMMITTEE AND THE BOARD OF DIRECTORS HAS THE RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT. THE AUDIT COMMITTEE MAKES RECOMMENDATIONS TO THE BOARD OF DIRECTORS IN REGARD TO THE SELECTION OF AN INDEPENDENT AUDITOR.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.
▶Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE WATERBURY HOSPITAL

Employer identification number
06-0665979

Part I **Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
CARDIOLOGY ASSOCIATES OF GREATER WATERBURY, LLC - 27-3828899, 455 CHASE PARKWAY, WATERBURY, CT 06708	CARDIOLOGY PRACTICE	CONNECTICUT	-3,143,116.	2,809,298.	THE WATERBURY HOSPITAL

Part II **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
GREATER WATERBURY HEALTH NETWORK, INC. - 22-2572044, 64 ROBBINS STREET, WATERBURY, CT 06721	HEALTH CARE MANAGEMENT	CONNECTICUT	501(C)(3)	11 TYPE 1	N/A		X
GREATER WATERBURY HEALTH SERVICES, INC. - 22-2572042, 64 ROBBINS STREET, WATERBURY, CT 06708	HEALTH SERVICES	CONNECTICUT	501(C)(3)	9	GREATER WATERBURY HEALTH NETWORK, INC.		X
ALLIANCE MEDICAL GROUP, INC. - 26-3520540 1625 STRAITS TURNPIKE, SUITE 211 MIDDLEBURY, CT 06762	HEALTH SERVICES	CONNECTICUT	501(C)(3)	9	THE WATERBURY HOSPITAL	X	

Part III **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
ACCESS REHAB CENTERS, LLC - 06-1527429, 22 TOMPKINS STREET, WATERBURY, CT 06708	THERAPY SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	683,838.	2,736,965.		X	N/A		X	65.00%
GREATER WATERBURY IMAGING CENTER, LLP - 06-1242903, 64 ROBBINS STREET, WATERBURY, CT 06721	IMAGING SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	964,832.	2,008,668.		X	N/A		X	63.64%
IMAGING PARTNERS, LLC - 06-1617047, 134 GRANDVIEW AVENUE, WATERBURY, CT 06708	IMAGING SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	58,240.	365,616.		X	N/A		X	85.00%
WATERBURY GASTROENTEROLOGY CO-MANAGEMENT COMPANY, LLC - 27-2417014, 64 ROBBINS STREET, WATERBURY, CT 06721	MEDICAL SERVICES	CT	THE WATERBURY HOSPITAL	RELATED	62,801.	145,595.		X	N/A		X	45.45%

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a	X	
b Gift, grant, or capital contribution to related organization(s)	1b	X	
c Gift, grant, or capital contribution from related organization(s)	1c		X
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j	X	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	X	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o Sharing of paid employees with related organization(s)	1o		X
p Reimbursement paid to related organization(s) for expenses	1p		X
q Reimbursement paid by related organization(s) for expenses	1q		X
r Other transfer of cash or property to related organization(s)	1r	X	
s Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) ACCESS REHAB CENTERS, LLC	A	69,673.	
(2) ACCESS REHAB CENTERS, LLC	L	1,373,769.	
(3) ALLIANCE MEDICAL GROUP	A	27,071.	
(4) GREATER WATERBURY IMAGING CENTER, LLP	A	105,628.	
(5) GREATER WATERBURY IMAGING CENTER, LLP	L	1,022,900.	
(6) ALLIANCE MEDICAL GROUP	B	60,364.	

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) ALLIANCE MEDICAL GROUP	R	8,152,669.	
(8)			
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) NO	(k) Percentage ownership

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS
AND OTHER FINANCIAL INFORMATION

SEPTEMBER 30, 2014 AND 2013

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONTENTS

MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT

Board of Trustees
The Waterbury Hospital

We have audited the accompanying consolidated financial statements of The Waterbury Hospital, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting polices used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of The Waterbury Hospital as of September 30, 2014 and 2013, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Marcum LLP

Hartford, CT
December 19, 2014

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

SEPTEMBER 30, 2014 AND 2013

	2014	2013
Assets		
Current Assets		
Cash and cash equivalents	$ 31,909,931	$ 23,993,423
Restricted cash	675,000	4,519,908
Short-term investments	507,699	472,637
Patient accounts receivable, less allowance ($9,207,000 in 2014 and $15,022,000 in 2013)	30,793,644	29,441,126
Grants and other receivables	3,843,762	3,702,524
Inventories of supplies	3,913,945	3,581,595
Prepaid insurance and other expenses	1,923,352	1,571,465
Total Current Assets	73,567,333	67,282,678
Other Assets		
Funds held in trust by others	46,117,761	44,960,039
Long-term investments	11,118,017	10,814,695
Board-designated endowment funds	3,315,500	3,193,664
Other receivables	77,952	171,972
Goodwill	1,813,567	1,813,567
CHEFA obligations issue expense, less amortization	243,686	282,676
	62,686,483	61,236,613
Property, plant and equipment:		
Land	287,549	287,549
Buildings and improvements	94,308,166	94,052,332
Equipment	188,064,397	186,912,261
Construction in progress	--	73,654
	282,660,112	281,325,796
Less accumulated depreciation	(246,745,886)	(238,890,019)
	35,914,226	42,435,777
	$ 172,168,042	$ 170,955,068

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS (CONTINUED)

SEPTEMBER 30, 2014 AND 2013

	2014	2013
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	$ 23,322,768	$ 21,578,227
Salaries, wages, payroll taxes and amounts withheld from employees	9,841,900	7,395,011
Due to third-party reimbursement agencies	4,171,981	2,969,391
Current portion of CHEFA obligations	493,776	472,136
Current portion of notes payable and capital lease obligations	461,705	694,549
Due to affiliates	600,116	2,042,951
Total Current Liabilities	38,892,246	35,152,265
Other Noncurrent Liabilities	25,354,977	21,813,507
CHEFA Obligations - less current portion	23,789,744	24,283,520
Notes Payable and Capital Lease Obligations - less current portion	438,984	852,568
Net Assets		
Unrestricted	23,336,473	29,976,833
Temporarily restricted	8,729,527	8,409,794
Permanently restricted	48,909,797	47,752,075
Total Net Assets Excluding Noncontrolling Interests	80,975,797	86,138,702
Noncontrolling Interests	2,716,294	2,714,506
Total Net Assets	83,692,091	88,853,208
	$ 172,168,042	$ 170,955,068

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Unrestricted Revenues		
Net patient service revenues	$ 248,836,314	$ 254,713,112
Provision for bad debts	(4,436,817)	(11,366,671)
Net patient service revenues less provision for bad debts	244,399,497	243,346,441
Other operating revenues	4,196,829	5,209,968
Net assets released from restrictions	5,542,491	5,419,591
	254,138,817	253,976,000
Operating Expenses		
Salaries	118,051,397	116,676,000
Employee benefits	29,379,803	30,913,497
Supplies and other	105,737,994	100,247,756
Depreciation	7,860,960	8,821,562
Interest and amortization	1,384,987	1,049,355
	262,415,141	257,708,170
Loss from Operations	(8,276,324)	(3,732,170)
Nonoperating Gains		
Unrestricted gifts and bequests	1,240,261	217,275
Investment income	1,840,688	1,737,423
	3,080,949	1,954,698
Deficiency of Revenues over Expenses Before Changes in Net Unrealized Gains on Investments	(5,195,375)	(1,777,472)
Changes in Net Unrealized Gains on Investments	92,827	268,235
Deficiency of Revenues over Expenses	(5,102,548)	(1,509,237)
Less Excess of Revenues over Expenses Attributable to Noncontrolling Interests	(926,677)	(874,685)
Deficiency of Revenues Over Expenses Attributable to Controlling Interest	(6,029,225)	(2,383,922)

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Unrestricted Net Assets, Controlling Interest		
Deficiency of revenues over expenses	$ (6,029,225)	$ (2,383,922)
Net assets released from restrictions used for purchase of property and equipment	13,360	19,654
Interest rate swap adjustment	217,110	1,209,256
Pension liability adjustments	(841,605)	903,495
Decrease in Unrestricted Net Assets, Controlling Interest	(6,640,360)	(251,517)
Unrestricted Net Assets, Noncontrolling Interest		
Excess of revenues over expenses	926,677	874,685
Distributions and other	(924,889)	(1,307,721)
Increase (Decrease) in Unrestricted Net Assets Noncontrolling Interest	1,788	(433,036)
Temporarily Restricted Net Assets		
Gifts and bequests	453,516	475,360
Income from investments	447,776	497,540
Net realized and unrealized gains on investments	604,989	810,002
Grants	4,369,303	4,420,717
Net assets released from restrictions	(5,555,851)	(5,439,245)
Increase in Temporarily Restricted Net Assets	319,733	764,374
Permanently Restricted Net Assets		
Increase in fair value of funds held in trust by others	1,157,722	2,741,876
Increase in Permanently Restricted Net Assets	1,157,722	2,741,876
(Decrease) Increase in Net Assets	(5,161,117)	2,821,697
Net Assets - Beginning	88,853,208	86,031,511
Net Assets - End	$ 83,692,091	$ 88,853,208

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Cash Flows from Operating Activities and Nonoperating Revenues		
Change in net assets	$ (5,161,117)	$ 2,821,697
Adjustments to reconcile change in net assets to net cash provided by operating activities and nonoperating revenues:		
Provision for bad debts	4,436,817	11,366,671
Depreciation and amortization	7,899,950	8,860,554
Pension liability adjustments	841,605	(903,495)
Distributions to noncontrolling interests	924,889	1,307,721
Net realized and unrealized gains and change in fair value of funds held in trust by others	(1,855,538)	(3,820,113)
Restricted gifts, bequests and income from investments	(901,292)	(972,900)
Change in market value of interest rate swap	(217,110)	(1,209,256)
	5,968,204	17,450,879
Changes in operating working capital other than cash and cash equivalents:		
Patient accounts receivable, net	(5,789,335)	(9,035,821)
Grants and other receivables	(141,238)	(725,020)
Inventories of supplies	(332,350)	(276,516)
Prepaid insurance and other expenses	(351,887)	(77,953)
Accounts payable and accrued expenses	1,744,541	(6,842,414)
Salaries, wages, payroll taxes and amounts withheld from employees	2,446,889	(930,163)
Due to third-party reimbursement agencies	1,202,590	2,368,120
Increase in other noncurrent liabilities	2,916,975	2,073,189
	1,696,185	(13,446,578)
Net Cash Provided by Operating Activities and Nonoperating Revenues	7,664,389	4,004,301

The accompanying notes are an integral part of these consolidated financial statements.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Cash Flows from Investing Activities		
Decrease (increase) in restricted cash	$ 3,844,908	$ (1,008,510)
Purchases of investments	(23,946,145)	(23,516,332)
Sales of investments	24,183,741	24,199,444
Cash paid to affiliates	(1,442,835)	(956,989)
Other assets	94,020	118,444
Additions to property, plant and equipment	(1,339,409)	(2,122,895)
Net Cash Provided by (Used in) Investing Activities	1,394,280	(3,286,838)
Cash Flows from Financing Activities		
Restricted gifts, bequests and income from investments	901,292	972,900
Distributions to noncontrolling interests	(924,889)	(1,307,721)
Proceeds from issuance of debt	55,580	157,781
Principal payments on debt obligations	(1,174,144)	(1,154,775)
Net Cash Used in Financing Activities	(1,142,161)	(1,331,815)
Net Increase (Decrease) in Cash and Cash Equivalents	7,916,508	(614,352)
Cash and Cash Equivalents - Beginning	23,993,423	24,607,775
Cash and Cash Equivalents - End	$ 31,909,931	$ 23,993,423

Supplemental Cash Flow Information

Cash paid during the year for interest on borrowings was $1,217,495 and $1,224,496 for the years ended September 30, 2014 and 2013, respectively.

The accompanying notes are an integral part of these consolidated financial statements.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION

ORGANIZATION

The Waterbury Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Greater Waterbury Health Network, Inc. (sole member) (the Network or GWHN). The Board of the Hospital, which is appointed by the Network, controls the operations of the Hospital. In addition to the Hospital, the accompanying financial statements include Access Rehab Centers, LLC (Access), Greater Waterbury Imaging Center Limited Partnership (GWIC), Imaging Partners, LLC, Alliance Medical Group, Inc. (AMG) and Cardiology Associates of Greater Waterbury, LLC (CAGW) to the extent of the Hospital's ownership interest in these subsidiaries and affiliated entities.

On October 29, 2012, the Network signed a Letter of Intent to develop a Joint Venture relationship with Vanguard Health Systems, Inc. (Vanguard) of Nashville, TN, a network of for-profit hospitals. Under terms of the proposed Joint Venture, the two organizations would form a Limited Liability Company in which Vanguard would have an 80 percent ownership interest and GWHN would have a 20 percent interest. The Joint Venture would acquire substantially all of the unrestricted assets and assume certain liabilities of the Hospital and GWHN. The Joint Venture would create a taxable, for-profit health system. On October 1, 2013, Tenet Healthcare Corporation (THC) completed its acquisition of Vanguard.

Approval from the State of Connecticut Office of Health Care Access (OHCA), the Office of the Attorney General, and from state and federal antitrust authorities is required.

A public hearing before the Office of the Attorney General and Office of Health Care Access was held on October 15, 2014. The Hospital received on December 1, 2014, proposed decision documents from the Office of the Attorney General and OHCA approving the proposed formation of the Joint Venture with Vanguard subject to certain conditions. Citing the number and restrictive nature of the conditions, Vanguard withdrew the application and on December 11, 2014 has publicly announced its decision not to pursue this transaction.

During November 2010, the Hospital established a limited liability company by the name of Cardiology Associates of Greater Waterbury, LLC to operate a cardiology practice. CAGW acquired the assets of Cardiology Associates of Waterbury (CAW), an unaffiliated entity, that were used by CAW physicians in the performance of their professional services.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

ORGANIZATION (CONTINUED)

The Waterbury Hospital also acquired the assets of CAW that were used by CAW to perform diagnostic ancillary services. The Hospital converted these ancillary services to provider-based services, which are provided at a diagnostic center located near the Hospital. The goodwill recorded on the consolidated balance sheets relates to the purchase of CAW.

During June 2010, the Hospital entered into an arrangement with certain gastroenterology physician-members of the Hospital's medical staff to form Waterbury Gastroenterology Co-Management Company, LLC (GI Co-Management Company), a Connecticut limited liability company. This company was formed as a collaborative effort between the Hospital and the physicians for the purpose of improving the quality and efficiency of the gastroenterology service line at the Hospital. The Hospital's investment of $50,000 in the GI Co-Management Company is included in the Hospital's consolidated financial statements in long-term investments.

The Hospital entered into a members' agreement, making it an equal member with St. Mary's Hospital, located in Waterbury, Connecticut, in a joint venture to form The Harold Leever Regional Cancer Center, Inc. (the Cancer Center). The Cancer Center is a Connecticut non-stock corporation exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The purpose of the joint venture is to develop, construct, own and operate the Cancer Center. Both member hospitals transferred the revenue and related expenses of their respective radiation oncology services to the Cancer Center in October 2002. Both member hospitals made working capital advances to the Cancer Center. The Cancer Center is not included in the Hospital's consolidated financial statements. During the year ended September 30, 2014, the Cancer Center provided a $1 million unrestricted grant to the Hospital that is included in unrestricted gifts and bequests in the consolidated statements of operations and changes in net assets.

The Hospital's major accounting policies are as summarized below and in Note 2.

PRINCIPLES OF CONSOLIDATION

The consolidated financial statements include the accounts of the Hospital, its subsidiaries and affiliated entities. Recognition has been given to noncontrolling interests in the affiliates which is reflected as a component of unrestricted net assets. All significant intercompany accounts and transactions are eliminated in consolidation.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated uncollectible accounts receivable for services to patients, and liabilities, including estimated net settlements with third-party reimbursement agencies and professional and pension liabilities, and disclosure of contingent assets and contingent liabilities at the date of the financial statements. Estimates also affect the amounts of revenues and expenses reported during the reporting period. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term. Actual results could differ from those estimates.

RECLASSIFICATIONS

Certain 2013 amounts were reclassified to conform to the 2014 presentation.

REGULATORY MATTERS

The Hospital is required to file annual operating information with OHCA.

TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily restricted net assets are available to provide grant related services, free care, and educational seminars. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity or in funds held in trust by others.

DONOR RESTRICTED GIFTS

Unconditional promises to give cash are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises to give are received. Amortization of the discounts is included in gifts and bequests on the consolidated statements of operations and changes in net assets.

The gifts are reported as either temporarily or permanently restricted net assets if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

CASH AND CASH EQUIVALENTS

The Hospital considers all highly liquid investments with remaining maturities of three months or less at date of purchase to be cash equivalents. Cash and cash equivalents are held at a limited number of financial institutions and at times, the amounts on deposit exceed insured limits.

RESTRICTED CASH

At September 30, 2014, the Hospital had a $4.5 million surety bond with an insurance company to support its self-insured workers' compensation program that was collateralized by an investment held by a bank. As of September 30, 2014, there were no borrowings on the surety bond.

At September 30, 2013, the Hospital had letters of credit totaling $4.5 million with banks to support its self-insured workers' compensation program that were collateralized by certain investments held by the banks. As of September 30, 2013, there were no borrowings on the letters of credit.

ACCOUNTS RECEIVABLE

Patient accounts receivable result from the health care services provided by the Hospital and its subsidiaries. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts.

The amount of the allowance for doubtful accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See Note 2 for additional information relative to net patient service revenues and third-party payor programs.

INVENTORIES

Inventories are stated at the lower of cost or market. The Hospital values its inventories using the first in first out method.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INVESTMENTS

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) and unrealized gains and losses are included in the deficiency of revenues over expenses unless the income or loss is restricted by donor or law.

Unrealized gains and losses on investments related to permanently restricted net assets and certain temporarily restricted net assets are included in temporarily restricted net assets under State law which allows the Board of Trustees to appropriate as much of the net appreciation of investments as is prudent considering the Hospital's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions. Reference is made to Note 5.

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment are recorded at cost. The Hospital and its subsidiaries provide for depreciation of property, plant and equipment and amortization of assets recorded under capital leases using the straight-line method in amounts sufficient to amortize the cost of the assets over their estimated useful lives which range from 3 to 40 years.

Financial Accounting Standards Board (FASB) ASC 410-20, *Accounting for Asset Retirement Obligations* (ASC 410-20), provides guidance on accounting and reporting for obligations associated with the retirement of tangible long-lived assets and the associated asset retirement costs. Asset retirement obligations include, but are not limited to, certain types of environmental issues which are legally required to be remediated upon an asset's retirement as well as contractually required asset retirement obligations. ASC 410-20 provides clarifying guidance on conditional asset retirement obligations. Conditional asset retirement obligations are obligations whose settlement may be uncertain. ASC 410-20's guidance requires such conditional asset retirement obligations to be estimated and recognized.

Conditional asset retirement obligations of $2,801,923 and $2,684,704 as of September 30, 2014 and 2013, respectively, are recorded in other noncurrent liabilities related to future asbestos remediation. During 2014 and 2013, there were no retirement obligations incurred or settled.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

GOODWILL

Goodwill, which has an indefinite life, is not amortized and is evaluated for impairment at least annually or whenever events or business conditions indicate that the carrying values of such assets may not be fully recoverable.

IMPAIRMENT OF LONG-LIVED ASSETS

The Hospital records impairment losses on long-lived assets used in operations when events and circumstances indicate that the assets might be impaired and the undiscounted cash flows estimated to be generated by those assets are less than the carrying amounts of those assets. There were no impairment losses recorded in 2014 and 2013.

NONOPERATING GAINS

Activities, other than in connection with providing health care services, are considered to be nonoperating. Nonoperating gains consist primarily of income on invested funds, gains and losses on sales of securities, changes in unrestricted unrealized gains and losses and unrestricted gifts and bequests.

DEFICIENCY OF REVENUES OVER EXPENSES

The consolidated statements of operations and changes in net assets include the deficiency of revenues over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from the deficiency of revenues over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), pension liability adjustments, and interest rate swap adjustments.

INCOME TAXES

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Hospital is also exempt from state income taxes. Access, GWIC, CAGW, and Imaging Partners LLC are partnerships. For tax purposes, these partnerships are pass-through entities. Taxation does not occur at the partnership level. Accordingly, no provision for taxes is included. AMG is tax exempt under Section 501 (c)(3) of the Internal Revenue Code.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INCOME TAXES (CONTINUED)

Management has analyzed the tax positions taken and has concluded that as of September 30, 2014, there are no uncertain tax positions taken or expected to be taken in that would require recognition of a liability (or asset) or disclosure in the financial statements. The Hospital is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes the Hospital is no longer subject to income tax examinations prior to 2011.

MEDICAL MALPRACTICE AND WORKERS' COMPENSATION INSURANCE

The Hospital has a policy of self-insuring the deductible portion of its workers' compensation claims. The deductible limit is $750,000 and $500,000 per claim for the years ended September 30, 2014 and 2013, respectively. Management records its best estimate of losses as they occur. The accrued workers' compensation self-insurance liabilities of $10,670,607 and $9,996,921 at September 30, 2014 and 2013, respectively, have been discounted at 2.25%.

Effective October 1, 2006, the Hospital obtained "claims-made" medical malpractice insurance coverage, through the Network, from Healthcare Alliance Insurance Company, Ltd. (HAIC) under retrospectively-rated policies whose ultimate premium is based primarily on the Hospital's experience. HAIC is a multi-provider captive insurance company domiciled in the Cayman Islands. The Network is a one half owner of HAIC with one other local hospital that also holds a 50% ownership. The Hospital's insurance coverage is $1,500,000 per occurrence and $5,000,000 in the aggregate. In addition to the coverage from HAIC, the Hospital recorded reserves of approximately $1,747,604 and $2,066,103 at September 30, 2014 and 2013, respectively, related to claims that were incurred subsequent to October 1, 2006, but not yet reported. These reserves were discounted at 2.25% at September 30, 2014 and 2013.

The Hospital also obtains excess insurance coverage for professional and general liability, through the Network, from HAIC. These policies have limits of $25,000,000 per claim and $25,000,000 aggregate, in excess of the underlying limits in the primary layer, for both professional and general liability.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

MEDICAL MALPRACTICE AND WORKERS' COMPENSATION INSURANCE (CONTINUED)

The Hospital also purchased a loss transfer insurance policy which provides $1,000,000 of coverage for each medical incident that was incurred between October 1, 2003 and October 1, 2006 and specifically reported to the insurance company on the effective date of the transfer policy (February 7, 2008) in addition to medical incidents incurred during the aforementioned period which are first reported after the effective date of the policy. This policy also provides $1,000,000 of coverage for general liability incurred but not reported claims that occurred after October 1, 2003 through October 1, 2006 and were first reported after the effective date of the policy. The policy has annual aggregate limits of $4,500,000 for medical incidents and $3,000,000 for general liability cases with a combined $25,000,000 total limit for all policy years. These aggregate limits are eroded by claims previously paid by the Hospital or other insurance.

RETIREMENT BENEFIT PLANS

The Hospital maintains a defined benefit pension plan for eligible individuals and participates in two multi-employer pension plans that cover certain union employees. Reference is made to Note 9.

OTHER NONCURRENT LIABILITIES

Other noncurrent liabilities include the long-term portion of liabilities for medical malpractice, workers' compensation, retirement benefits, the interest rate swap, and conditional asset retirement obligations.

RISKS AND UNCERTAINTIES

The Hospital invests in a variety of investment securities which are exposed to various risks, such as interest rate risk, financial market risk, currency risk and credit risk. Due to the level of risk associated with investment securities, coupled with economic events, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the Hospital's September 30, 2014 financial statements, in addition to the funded status of its defined benefit pension plan.

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

BAD DEBTS

ASU 2011-07, *Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*, requires certain health care entities to present the provision for bad debts associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense with enhanced footnote disclosures on the policies for recognizing revenue and assessing bad debts, in addition to qualitative and quantitative information about changes in the allowance for doubtful accounts. Refer to Note 2 for the additional disclosures required by ASU 2011-07.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE

The following table summarizes net patient service revenues:

	2014	2013
Gross patient service revenues	$ 985,407,726	$ 936,820,801
Deductions (additions)		
Allowances	734,714,169	683,010,134
Regulatory	1,857,243	(902,445)
	736,571,412	682,107,689
Net patient service revenues	248,836,314	254,713,112
Provision for bad debts	4,436,817	11,366,671
Net patient service revenues less provision for bad debts	$ 244,399,497	$ 243,346,441

Patient accounts receivable and revenues are recorded when patient services are performed.

Amounts received from most payors are different from the established billing rates of the Hospital, and these differences are accounted for as allowances. Net revenues have been affected by State of Connecticut Disproportionate Share program in 2014 and 2013 which is reflected in the regulatory amounts in the table above.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. For the years ended September 30, 2014 and 2013, the Hospital recorded approximately $2,500,000 and $2,400,000, respectively, as a decrease to net patient service revenues as changes in estimates related to third-party payor settlements and adjustments to accruals recorded in prior years.

During 2014 and 2013, approximately 44% and 37%, respectively, of net patient service revenues were received under the Medicare program, 10% and 16%, respectively, under the state Medicaid program, and 46% and 47%, respectively, from contracts with other third-parties.

Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital. The State of Connecticut has implemented reductions in the State's Disproportionate Share Reimbursement Program for the period from July 1, 2012 through June 30, 2015.

The current Connecticut Medicaid inpatient hospital reimbursement model of interim per diem rates and case rate settlements will transition to an All Patient Refined Diagnosis Related Group System (APR-DRG) where hospital payments will be established prospectively. Connecticut Medicaid outpatient hospital reimbursement will move from the current system of reimbursement based on Revenue Center Codes to a prospective payment system based on the complexity of services performed. The specific transition plan has not been finalized by the State of Connecticut, but the new inpatient reimbursement methodology may be implemented as early as January 1, 2015; while the new outpatient reimbursement methodology will not be implemented until at least the second half of fiscal year 2016. The Hospital has not determined the estimated impact of these proposed changes on net patient service revenues in future years.

The significant concentrations of net accounts receivable for services to patients include 44% from Medicare, 15% from Medicaid, 28% from commercial insurance carriers and 13% from others at September 30, 2014 (44%, 13%, 24% and 19%, respectively, in 2013).

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. The Hospital believes that it is in compliance with all applicable laws and regulations. Cost reports for the Hospital, which serve as a basis for final settlement with government payors, have been settled by final settlement through 2011 for Medicare and 1995 for Medicaid. Other years remain open for settlement.

The Hospital has agreements with various Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the HMOs make fee-for-service payments to the Hospital for certain covered services based upon discounted fee schedules.

ALLOWANCE FOR DOUBTFUL ACCOUNTS

The Hospital's estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Hospital's collection efforts. The Hospital's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as the charges are recorded. On a monthly basis, the Hospital reviews its accounts receivable balances, the effectiveness of the Hospital's reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

- Revenue and volume trends by payor, particularly the self-pay components;
- Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;
- Various allowance coverage statistics.

The Hospital regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for doubtful accounts.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

ALLOWANCE FOR DOUBTFUL ACCOUNTS (CONTINUED)

A summary of the Hospital's allowance for doubtful accounts activity for the years ended September 30, 2014 and 2013 is as follows:

	Balance at Beginning of Period	Additions Recorded in the Provision for Bad Debts	Accounts Written off, Net of Recoveries and Other	Balance at End of Period
Allowance for doubtful accounts:				
Year ended September 30, 2013	$(11,683,000)	$(11,366,671)	$ 8,027,671	$(15,022,000)
Year ended September 30, 2014	(15,022,000)	(4,436,817)	10,251,817	(9,207,000)

MEASURING CHARITY CARE

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is possible. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized Federal poverty income levels, but also includes certain cases where incurred charges are significant when compared to incomes and assets. These services are not included in net patient service revenues for financial reporting purposes.

The Hospital implemented effective October 1, 2013 a change to its charity care policy to discount all self-pay receivables by 50 percent upon final billing. These self-pay discounts amounted to approximately $5.2 million for the year ended September 30, 2014 and were previously included in the provision for bad debts and the allowance for doubtful accounts.

Self-pay revenues are derived primarily from patients who do not have any form of health care coverage. The Hospital evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the Hospital's policy for charity care. The Hospital provides care without charge to certain patients that qualify under its charity care policy. For the years ended September 30, 2014 and 2013, the Hospital estimates that its costs of care provided under its charity care programs approximated $1,383,000 and $440,000, respectively.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

MEASURING CHARITY CARE (CONTINUED)

The Hospital's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Hospital's gross charity care charges provided. The Hospital's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Hospital's charity care policy. To the extent the Hospital receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Hospital does not include these patients' charges in its cost of care provided under its charity care program. Additionally, the Hospital does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Hospital's policy not to pursue collection of amounts related to these patients.

ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS

The American Recovery and Reinvestment Act of 2009 (ARRA) included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are also available to providers that adopt, implement or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

Income from Medicare incentive payments is recognized as revenue after the Hospital has demonstrated that it complied with the meaningful use criteria over the entire applicable compliance period. The Hospital recognized revenue from Medicaid and Medicare for incentive payments after it adopted certified EHR technology. Medicaid incentive payments were $322,653 and $483,979 for the years ended September 30, 2014 and 2013, respectively. Medicare incentive payments were $1,184,857 and $1,793,771 for the years ended September 30, 2014 and 2013, respectively. Incentive payments are included in other operating revenues in the accompanying consolidated statements of operations and changes in net assets. Income from incentive payments is subject to retrospective adjustment as the incentive payments are calculated using Medicare cost report data that is subject to audit. Additionally, the Hospital's compliance with the meaningful use criteria is subject to audit by the federal government.

NOTE 2 - NET PATIENT SERVICE REVENUES AND CHARITY CARE (CONTINUED)

ICD-10 IMPLEMENTATION

The Hospital is subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically.

In January 2009, the Centers for Medicare and Medicaid Services (CMS) published its tenth revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10) and related changes to the formats used for certain electronic transactions. ICD-10 contains significantly more diagnostic and procedural codes than the existing ICD-9 coding system, and as a result, the coding for the patient services provided in the Hospital will require much greater specificity when ICD-10 becomes effective on October 1, 2015.

The implementation of ICD-10 will require a significant investment in technology and training. The Hospital may experience delays in reimbursement while the Hospital and the payors from which it seeks reimbursement make the transition to ICD-10. If the Hospital fails to implement the new coding systems by the deadline, the Hospital will not be paid for services. Management is not able to reasonably estimate the overall financial statement impact of the Hospital's transition to ICD-10.

NOTE 3 - INVESTMENTS

The composition of investments, including other assets and funds held in escrow is set forth in the following table. Investments are stated at fair value:

	2014		2013	
	Cost	Fair Value	Cost	Fair Value
Short-term investments:				
Certificates of deposit and mutual funds	$ 424,925	$ 507,699	$ 406,088	$ 472,637
Investments of funds held in trust by others	$ 42,013,991	$ 46,117,761	$ 36,611,831	$ 44,960,039
Long-term investments and Board - designated endowment funds:				
Certificates of deposit and money market funds	$ 873,669	$ 873,669	$ 901,472	$ 901,472
Marketable equity securities	197,835	351,238	197,835	287,008
U.S. Government obligations	108,451	149,445	108,451	154,567
Corporate bonds	3,680,469	3,686,721	3,412,334	3,396,880
Mutual funds	7,799,302	9,013,644	7,708,657	8,908,523
	$ 12,659,726	$ 14,074,717	$ 12,328,749	$ 13,648,450

The Hospital had long-term investments in partnerships and joint ventures that were recorded at cost of $358,800 and $359,909 as of September 30, 2014 and 2013, respectively, as it was not practicable to estimate fair value. These investments are not included in the tables above.

Unrestricted investment income, including income on funds held in trust by others and gains are comprised of the following for the years ended September 30, 2014 and 2013:

	2014	2013
Income		
Interest and dividends	$ 1,832,085	$ 1,737,423
Realized gains on sales of investments	8,603	--
Changes in net unrealized gains on investments	92,827	268,235
	$ 1,933,515	$ 2,005,658

NOTE 4 - FAIR VALUE MEASUREMENTS

The Hospital categorizes assets and liabilities for disclosure purposes based on whether the inputs used to determine their fair values are observable or unobservable. The Hospital utilizes a three-level fair value hierarchy that prioritizes the inputs used to measure assets at fair value. Level inputs are as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Hospital has the ability to access on the reporting date.

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset.

Level 3 – Inputs that are unobservable for the asset or liability.

The fair values of Level 1 securities were determined through quoted market prices, while fair values of Level 2 securities were determined primarily through prices obtained from third party pricing sources, where quoted market prices for such securities are not available. The fair values of Level 3 securities were determined primarily through information obtained from the relevant counterparties for such assets or liabilities, as information on which these fair values are based is generally not readily available in the market.

The fair value of the interest rate swap was determined by the counterparty based on an estimate of the net present value of the expected cash flows using relevant mid-market data inputs and based on the assumption of no unusual market conditions or forced liquidation.

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

The following table summarizes fair value measurements, by level, at September 30, 2014, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 35,728,709	$ --	$ --	$ 35,728,709
Common stock-Insurance	133,496	--	--	133,496
Mutual funds:				
U.S. large cap	21,147,966	--	--	21,147,966
U.S. mid cap	3,399,506	--	--	3,399,506
U.S. small cap	2,786,261	--	--	2,786,261
International developed	4,979,700	--	--	4,979,700
Emerging markets	3,076,127	--	--	3,076,127
Fixed income securities:				
Investment grade taxable	1,978,762	12,122,021	--	14,100,783
International developed bonds	--	695,404	--	695,404
Global high yield taxable	5,296	2,420,636	--	2,425,932
Real estate investment trusts	2,506,598	--	--	2,506,598
Other	1,758,038	546,588	--	2,304,626
Total investments at fair value	$ 77,500,459	$ 15,784,649	$ --	$ 93,285,108
Liabilities:				
Interest rate swap	$ --	$ 1,512,596	$ --	$ 1,512,596

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

The following table summarizes fair value measurements, by level, at September 30, 2013, for all assets and liabilities which are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 31,081,328	$ --	$ --	$ 31,081,328
Common stock-Insurance	93,309	--	--	93,309
Mutual funds:				
U.S. large cap	23,645,248	--	--	23,645,248
U.S. mid cap	3,460,785	--	--	3,460,785
U.S. small cap	3,034,881	--	--	3,034,881
International developed	4,960,376	--	--	4,960,376
Emerging markets	2,705,380	--	--	2,705,380
Fixed income securities:				
Investment grade taxable	2,042,330	11,202,070	--	13,244,400
International developed bonds	1,237	719,184	--	720,421
Global high yield taxable	261,841	2,027,557	--	2,289,398
Real estate investment trusts	1,972,747	--	--	1,972,747
Other	101,506	284,678	--	386,184
Total investments at fair value	$ 73,360,968	$ 14,233,489	$ --	$ 87,594,457
Liabilities:				
Interest rate swap	$ --	$ 1,729,706	$ --	$ 1,729,706

NOTE 5 - RESTRICTED ENDOWMENTS

The Hospital's endowments consist of donor-restricted endowment funds and Board-designated endowment funds. Net assets associated with endowment funds are classified and reported based on donor-imposed restrictions.

The Hospital's Board of Trustees has interpreted the Connecticut Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and, if applicable (c) accumulations to the permanent endowment made in accordance with the related gift's donor instructions. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard for expenditure as proscribed by UPMIFA. In accordance with UPMIFA, the Hospital considers the following factors in making determinations to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund
(2) The purposes of the Hospital and the donor-restricted endowment fund
(3) General economic conditions
(4) The possible effect of inflation and deflation
(5) The expected total return from income and the appreciation of investments
(6) Other resources of the Hospital
(7) The investment policies of the Hospital

RETURN OBJECTIVES AND RISK PARAMETERS

For the permanently restricted endowment funds, the bank, acting in its capacity as trustee, determines and directs the investment policy and asset allocation. For the unrestricted and temporarily restricted endowment funds, the Hospital's Board of Trustees has adopted investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. The Hospital expects these endowment funds, over time, to provide an average rate of return that exceeds the rate of inflation by 3.5% annually. Actual returns in any given year may vary from this amount.

NOTE 5 - RESTRICTED ENDOWMENTS (CONTINUED)

STRATEGIES EMPLOYED FOR ACHIEVING OBJECTIVES

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

SPENDING POLICY AND HOW THE INVESTMENT OBJECTIVES RELATE TO SPENDING POLICY

The Hospital has a policy of evaluating the spending decisions for each endowment fund based upon the intentions of the donors and specific contractual agreements. In determining the annual amount to be spent, the Hospital considers the long-term expected return on its endowment. The spending policy is designed to limit spending to the expected long-term real rate of return. The annual distribution from the endowment funds is expected to be contained within a range of 4-6% of the trusts' market value. This is consistent with the Hospital's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2014

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 7,607,185	$ 48,909,797	$ 56,516,982
Board-designated endowment funds	3,315,500	--	--	3,315,500
Total funds	$ 3,315,500	$ 7,607,185	$ 48,909,797	$ 59,832,482

NOTE 5 - RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2014

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 3,193,664	$ 7,446,152	$ 47,752,075	$ 58,391,891
Investment return:				
Investment income	56,642	184,580	--	241,222
Net appreciation (realized and unrealized)	203,276	612,338	1,157,722	1,973,336
Total investment return	259,918	796,918	1,157,722	2,214,558
Appropriation of endowment assets for expenditure	(138,082)	(635,885)	--	(773,967)
Endowment net assets, ending balance	$ 3,315,500	$ 7,607,185	$ 48,909,797	$ 59,832,482

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ --	$ 7,446,152	$ 47,752,075	$ 55,198,227
Board-designated endowment funds	3,193,664	--	--	3,193,664
Total funds	$ 3,193,664	$ 7,446,152	$ 47,752,075	$ 58,391,891

NOTE 5 - RESTRICTED ENDOWMENTS (CONTINUED)

CHANGES IN ENDOWMENT NET ASSETS FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning balance	$ 2,974,503	$ 6,806,683	$ 45,010,199	$ 54,791,385
Investment return:				
Investment income	72,896	238,568	--	311,464
Net appreciation (realized and unrealized)	277,353	829,688	2,741,876	3,848,917
Total investment return	350,249	1,068,256	2,741,876	4,160,381
Appropriation of endowment assets for expenditure	(131,088)	(428,787)	--	(559,875)
Endowment net assets, ending balance	$ 3,193,664	$ 7,446,152	$ 47,752,075	$ 58,391,891

NOTE 6 - TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Permanently restricted net assets at September 30, 2014 and 2013 are restricted amounts which are to be held in perpetuity, the income from which is expendable to provide free care, scholarships for the children of the Hospital's employees, and for the operations of the Hospital. Also included in permanently restricted net assets are funds held in trust by others. The Hospital is the restricted income beneficiary of funds held in trust by others. The total trust assets, as reported by the trustees, had an aggregate fair value at September 30, 2014 and 2013 of $46,117,761 and $44,960,039, respectively. Distributions of $2,023,580 and $1,896,981 from these assets for the years ended September 30, 2014 and 2013, respectively, is included in investment income.

Temporarily restricted net assets are available to provide psychiatric services, free care and educational seminars.

NOTE 6 - TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS (CONTINUED)

During 2014 and 2013, net assets were released from donor restrictions by incurring expenses which satisfied the restricted purposes in providing grant related services, free care, and various miscellaneous services in the amounts of $4,369,303, $688,243 and $484,945, respectively in 2014 and $4,420,717, $657,253 and $341,621, respectively in 2013. In addition, $13,360 and $19,654 were released for the purchase of property and equipment in 2014 and 2013, respectively.

NOTE 7 - DEBT

SERIES D BOND FINANCING

In December 2010, the Hospital refinanced its Series C bond financing and financed an additional $8,000,000 for various capital projects that were completed over a two-year period. The par amount of the Series D debt was $25,918,000 and interest is variable at the interest rate that is equal to the product of (i) sixty-eight percent (68%) and (ii) the sum of the LIBOR Rate and three hundred basis points (2.15% at September 30, 2014). The bonds require monthly principal and interest payments, based upon a 10-year amortization schedule, from 2011 through 2020 with the remaining principal balance due in 2020.

The terms of the bonds provide for, among other things, a pledge of gross receipts of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and provide for covenants regarding the Hospital's debt service coverage ratios, minimum levels of cash on hand, sale and lease of assets and other covenants similar in financings of this type.

In connection with this refinancing, the Hospital entered into an interest rate swap with a bank, which allowed it to convert its variable interest rate liability to a fixed interest rate liability of 4.475% without changing the structure of the underlying debt.

The Hospital uses the interest rate swap agreement to manage interest rate risk associated with its outstanding debt. At September 30, 2014 and 2013, the notional value of outstanding interest rate swap was $24,283,520 and $24,755,656, respectively.

The Hospital recognizes the fair value of its interest rate swap in the consolidated balance sheet as a liability, recorded in other noncurrent liabilities. At September 30, 2014 and 2013, the fair value of interest rate swap was in a liability position of $1,512,596 and $1,729,706, respectively.

The Hospital designated its interest rate swap as a cash flow hedge for accounting purposes, and accordingly defers gains or losses associated with the swap in net assets.

NOTE 7 - DEBT (CONTINUED)

Future minimum payments by year and in the aggregate under the Series D bond financing are as follows at September 30, 2014:

2015	$ 493,776
2016	516,408
2017	540,080
2018	564,832
2019	590,716
Aggregate thereafter	21,577,708
	$ 24,283,520

OTHER DEBT

Access has a $250,000 line of credit with a bank. There were no borrowings under this line of credit at September 30, 2014 and 2013.

AMG had a capital lease for equipment that called for monthly payments of $593 through January 2014 and was secured by the equipment. The balance of the capital lease liability was zero at September 30, 2014 and $2,858 at September 30, 2013.

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $353 through March 2015 and is secured by the equipment. The balance of the capital lease liability was $1,993 at September 30, 2014 and $5,877 at September 30, 2013.

AMG entered into an equipment lease during 2010. The lease calls for monthly payments of $447 through May 2015 and is secured by the equipment. The balance of the capital lease liability was $3,883 at September 30, 2014 and $8,687 at September 30, 2013.

AMG entered into a capital lease for equipment during 2014. The balance of the capital lease liability was $48,121 at September 30, 2014.

The Hospital entered into a capital lease for equipment during 2011. The lease calls for equal monthly payments of $20,885 through May 2016 and is secured by the equipment. The balance of the capital lease liability was $379,070 at September 30, 2014 and $609,435 at September 30, 2013.

NOTE 7 - DEBT (CONTINUED)

AMG entered into a term note during 2010 at an interest rate of 9.8%. The note calls for monthly payments of $13,216 through November 2014 and is secured by the assets of AMG. The balance of the term note liability was $26,101 at September 30, 2014 and $173,794 at September 30, 2013.

AMG assumed a note payable during 2009 for the fit-up of office space. The original amount of the note was $320,000 and was repayable in installments of principal plus interest at 7.50% totaling $4,908 per month through January 2014. In addition, this note called for a final payment of principal and interest of $113,981 in February 2014. The balance of this note was zero at September 30, 2014 and $129,815 at September 30, 2013.

The Hospital entered into a capital lease for equipment during 2012. The lease calls for equal monthly payments of $11,469 through August 2017 and is secured by the equipment. The balance of the capital lease liability was $376,940 at September 30, 2014 and $495,826 at September 30, 2013.

The Hospital entered into a capital lease for equipment during 2013. The lease calls for equal monthly payments of $4,779 through November 2015. The balance of capital lease liability was $64,581 at September 30, 2014 and $120,825 at September 30, 2013.

Future minimum payments by year and in the aggregate for all obligations other than the CHEFA Series D bonds were as follows at September 30, 2014:

2015	$ 461,705
2016	294,554
2017	138,132
2018	6,298
	$ 900,689

The fair value of the debt, using the discounted cash flow analyses, was approximately $26,697,000 at September 30, 2014 and $28,032,000 at September 30, 2013.

NOTE 8 - RENTAL EXPENSE AND LEASE COMMITMENTS

The Hospital has entered into operating leases for office space and office equipment. Rental expense is recorded on a straight-line basis over the terms of the leases. Rental expense for the years ended September 30, 2014 and 2013 was $4,441,474 and $4,740,477, respectively. The minimum rental commitments under all noncancellable operating leases with initial or remaining terms of more than one year are as follows:

2015	$ 4,241,725
2016	3,914,897
2017	2,892,657
2018	1,547,444
2019	114,032
Thereafter	195,408
	$ 12,906,163

NOTE 9 - EMPLOYEE BENEFIT PLANS

The Hospital has a noncontributory defined benefit cash balance plan (the Plan). Under the Plan, each participant who elected to transfer their balances to the Plan from the former defined contribution plan receives a credit of 6% of compensation allocated to their cash balance accounts. All other participants receive a 3% credit. Additionally, each participant receives an interest credit to their cash balance account based on the yield to maturity on three-year treasury bills. The Plan covers substantially all non-union employees age 21 and older with one year of service. It is the Hospital's policy to make contributions to the Plan sufficient to meet the minimum funding requirements of applicable laws and regulations.

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

Following is a summary of the Plan's funded status using the measurement dates of September 30, 2014 and 2013 and amounts recognized in the Hospital's consolidated financial statements.

	2014	2013
Change in benefit obligation		
Benefit obligation beginning of year	$ (35,562,211)	$ (37,888,825)
Service cost	(1,466,890)	(1,702,273)
Interest cost	(1,324,043)	(1,154,537)
Actuarial (loss) gain	(1,095,038)	2,126,771
Benefits paid	3,211,209	3,056,653
Benefit obligation, end of year	$ (36,236,973)	$ (35,562,211)
Change in plan assets		
Fair value of plan assets, beginning of year	$ 27,201,671	$ 28,843,113
Actual return on plan assets	696,625	253,055
Employer contributions	1,301,618	1,162,156
Benefits paid	(3,211,209)	(3,056,653)
Fair value of plan assets, end of year	$ 25,988,705	$ 27,201,671
Funded status	$ (10,248,268)	$ (8,360,540)
Accrued pension liability	$ (10,248,268)	$ (8,360,540)
Components of net periodic pension cost		
Service cost	$ 1,466,890	$ 1,702,273
Interest cost	1,324,043	1,154,537
Expected return on plan assets	(1,294,305)	(2,483,658)
Amortization of actuarial loss	816,016	971,872
Amortization of prior service cost	35,097	35,455
Net periodic pension cost	$ 2,347,741	$ 1,380,479
Accumulated benefit obligation	$ 35,271,477	$ 34,675,898

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

Included in unrestricted net assets are the following amounts that have not yet been recognized in net periodic cost:

	2014	2013
Unrecognized prior service cost	$ (121,434)	$ (156,531)
Unrecognized actuarial losses	(15,649,501)	(14,772,799)
Benefit obligation, end of year	$ (15,770,935)	$ (14,929,330)

Changes in benefit obligations recognized in unrestricted net assets include:

	2014	2013
Current year actuarial losses	$ (1,692,718)	$ (103,832)
Amortization of prior service cost	35,097	35,455
Amortization of net loss	816,016	971,872
	$ (841,605)	$ 903,495

The prior service cost and actuarial losses included in unrestricted net assets and expected to be recognized in net periodic cost during the year ending September 30, 2015 are $35,097 and $1,108,503, respectively.

ASSUMPTIONS

The weighted-average assumptions used to determine benefit obligations at September 30 are as follows:

	2014	2013
Discount rate	3.55%	3.99%
Expected return on plan assets	4.50%	8.00%
Rate of compensation increase	2.00% for 2 year select period, 3.00% ultimate	2.00% for 3 year select period, 3.00% ultimate

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

The weighted-average assumptions used to determine net periodic benefit cost for years ended September 30 are as follows:

	2014	2013
Discount rate	3.99%	3.17%
Expected return on plan assets	4.50%	8.00%
Rate of compensation increase	2.00% for 3 year select period, 3.00% ultimate	2.00% for 4 year select period, 3.00% ultimate

EXPECTED LONG-TERM RETURN ON PLAN ASSETS

To develop the expected long-term rate of return on assets assumptions, the Hospital considered the historical returns and the future expectations of returns for each asset class, as well as target asset allocations of the pension portfolio. This resulted in the selection of the 4.5% and 8.0% long-term rate of return at September 30, 2014 and 2013, respectively.

INVESTMENT POLICY

The Plan's weighted-average asset allocations at September 30, 2014, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
U.S. Equity	5%	5%	3% - 7%
Non-U.S. Equity	5%	5%	3% - 7%
Core fixed income	90%	90%	86% - 94%

The Plan's weighted-average asset allocations at September 30, 2013, by asset category are as follows:

		Asset Allocation Policy	
Asset Category	Plan Assets	Target	Range
Global defensive equity unhedged	10%	10%	5% - 15%
Custom fixed income	90%	90%	85% - 95%

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

The Pension Committee of the Board of Trustees (the Committee) is responsible for employee benefit program policies with respect to plan assets and the retention of qualified managers, consultants and trustee/custodians. The purpose of the Committee is to ensure the Plan assets accumulate monies required to meet the anticipated benefit payments of the Plan and contributions are made by the Hospital on a basis determined by the Plan's actuary to be adequate to fund the benefits. The investment objective of the Committee is to maximize total return after inflation within the limits of prudent risk taking by diversifying across asset classes and multiple managers. The Committee has established an asset allocation policy that sets a target and range for each asset class, as shown in the table above.

CONTRIBUTIONS

The Hospital expects to make $1,204,000 in contributions to the Plan in 2015.

ESTIMATED FUTURE BENEFIT PAYMENTS

The following benefit payments, which reflect expected future service, are expected to be paid as follows:

2015	$ 3,388,000
2016	3,431,000
2017	3,305,000
2018	3,619,000
2019	3,287,000
2020-2024	15,109,000
	$ 32,139,000

As required by ASC 820, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

The following table sets forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2014.

	Level 1	Level 2	Level 3	Total
Commingled funds and private equity	$ --	$ --	$25,988,705	$25,988,705

The following table sets forth by level within the fair value hierarchy the investment assets and investment liabilities at fair value, as of September 30, 2013.

	Level 1	Level 2	Level 3	Total
Commingled funds and private equity	$ --	$ --	$27,201,671	$27,201,671

The following is a reconciliation of Level 3 assets for which significant unobservable inputs were used to determine fair value:

	2014	2013
Balance as of beginning of fiscal year	$ 27,201,671	$ 19,307,214
Change in unrealized appreciation (depreciation)	570,424	(487,433)
Purchases	5,571,007	52,316,941
Sales	(7,354,397)	(43,935,051)
Balance as of September 30,	$ 25,988,705	$ 27,201,671

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

OTHER BENEFIT PLANS

The Hospital participates in multi-employer pension plans that cover substantially all union employees. Contributions to the plans are based upon a percentage of each participant's total salary. The risks of participating in these multi-employer plans are different from single-employer plans in the following aspects:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of another participating employer.

- If a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers.

- If the Hospital chose to stop participating in the multi-employer plans, it would be required to pay those plans an amount based on the underfunded status of the plans, referred to as a withdrawal liability.

The following table presents the Hospital's participation in these plans as of and for the years ended September 30, 2014 and 2013.

Pension Trust Fund	Pension Plan Employer Identification Number	Pension Protection Act ("PPA") Certified Zone Status[1] 2014	2013	FIP / RP Status Pending / Implemented[2]	Contributions 2014	2013	Surcharge Imposed	Expiration Date of Collection Bargaining Agreement[3]
Connecticut Health Care Associates Pension Fund	06-1313462	Green	Green	N/A	$ 2,074,142	$ 2,077,612	No	September 30, 2017
New England Health Care Employees Pension Fund	22-3071963	Green	Green	N/A	688,949	783,235	No	February 29, 2016
				Total Contributions:	$ 2,763,091	$ 2,860,847		

[1] The most recent PPA zone status available in 2014 and 2013 is for the plan's year-ending during 2013 and 2012, respectively. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.

[2] The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented.

[3] Lists the expiration dates of the collective-bargaining agreements to which the plans are subject.

During the years ended September 30, 2014 and 2013, the Hospital's contributions to the Connecticut Health Care Associates Pension Plan represented 98.6% and 96.0% of the total contributions made to the plan by all participating employers, respectively.

During the years ended September 30, 2014 and 2013, the Hospital's contributions to the New England Health Care Employees Pension Plan represented 2.8% and 3.0% of the total contributions made to the plan by all participating employers, respectively.

NOTE 9 - EMPLOYEE BENEFIT PLANS (CONTINUED)

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. The Hospital has explored the costs to withdraw from the Connecticut Health Care Associates (CHCA) Pension Plan in the event that the Hospital enters into a transaction. If the Hospital was to withdraw, it is expected that CHCA will likewise withdraw from the pension plan making a total withdrawal liability for the Hospital of approximately $27,700,000.

In addition, the Hospital has a supplemental employee retirement plan for certain executives. The plan provides for a total benefit and is partially funded. As of September 30, 2014 and 2013, liabilities of $330,148 and $240,869, respectively, have been reflected in the consolidated balance sheets.

As noted above, the Hospital also has a noncontributory defined benefit cash balance plan covering substantially all non-union employees age 21 and older with one year of service. Total pension expense, relating to this plan, charged to operations during the years ended September 30, 2014 and 2013 was $2,347,741 and $1,380,479, respectively.

NOTE 10 - SELF-INSURANCE CLAIMS

There have been medical malpractice and workers' compensation claims that fall within the Hospital's partially self-insured program which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2014 that may result in the assertion of claims. Hospital management has accrued its best estimate of these contingent losses. Other claims may be asserted arising from services provided to patients or workers' compensation incidents in the past. Hospital management has provided reserves for these contingent liabilities.

NOTE 11 - CONTINGENCIES

The Hospital is a party to various lawsuits incidental to its business.

NOTE 12 - DUE TO AFFILIATES

The amounts due to affiliates of $600,116 and $2,042,951 at September 30, 2014 and 2013, respectively, represent (payables) to and receivables from affiliates that do not eliminate in consolidation. These balances are comprised of the following:

	2014	2013
Greater Waterbury Health Network, Inc.	$ (430,440)	$ (1,885,946)
Alliance Medical Group of Greater Waterbury, P.C.	(9,983)	(9,983)
Greater Waterbury Management Resources, Inc.	(162,693)	(162,693)
GI Co-Management Company	3,000	1,500
Children's Center of Greater Waterbury Health Network, Inc.	--	14,171
	$ (600,116)	$ (2,042,951)

NOTE 13 - FUNCTIONAL EXPENSES

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows:

	2014	2013
Health care services	$ 194,695,917	$ 193,831,378
General and administrative	67,341,789	63,524,487
Fundraising	377,435	352,305
	$ 262,415,141	$ 257,708,170

NOTE 14 - SUBSEQUENT EVENTS

The Hospital evaluates the impact of subsequent events, events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date or for disclosure in the notes to the financial statements. The Hospital evaluated events occurring subsequent to September 30, 2014 through December 19, 2014, the date on which the accompanying consolidated financial statements were available to be issued. During this period, there were no subsequent events that required recognition in the consolidated financial statements. Reference is made to Note 1 regarding the disclosure of subsequent events related to the proposed Joint Venture with Vanguard.

MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT
ON OTHER FINANCIAL INFORMATION

Board of Trustees
The Waterbury Hospital

We have audited the consolidated financial statements of The Waterbury Hospital as of and for the years ended September 30, 2014 and 2013, and our report thereon dated December 19, 2014, which contained an unmodified opinion on those consolidated financial statements, appears on pages 1-2. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information is presented for the purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Marcum LLP

Hartford, CT
December 19, 2014

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2014

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Assets								
Current Assets								
Cash and cash equivalents	$ 26,817,453	$ 1,246,774	$ 2,192,258	$ 421,661	$ 1,048,604	$ 183,181	$ --	$ 31,909,931
Restricted cash	675,000	--	--	--	--	--	--	675,000
Short-term investments	--	--	507,699	--	--	--	--	507,699
Patient accounts receivable, net	26,853,209	874,082	1,610,880	--	1,428,376	479,375	(452,278)	30,793,644
Grants and other receivables	3,603,082	--	--	338	92,192	172,024	(23,874)	3,843,762
Inventories of supplies	3,694,606	--	30,346	--	185,876	3,117	--	3,913,945
Prepaid insurance and other expenses	1,493,653	--	54,850	4,814	235,813	134,222	--	1,923,352
Total Current Assets	63,137,003	2,120,856	4,396,033	426,813	2,990,861	971,919	(476,152)	73,567,333
Other Assets								
Funds held in trust by others	46,117,761	--	--	--	--	--	--	46,117,761
Long-term investments	11,017,660	38,776	61,581	--	--	--	--	11,118,017
Board-designated endowment funds	3,315,500	--	--	--	--	--	--	3,315,500
Other receivables	77,952	--	--	--	--	--	--	77,952
Goodwill	200,500	--	--	--	--	1,613,067	--	1,813,567
CHEFA obligations issue expense, less amortization	243,686	--	--	--	--	--	--	243,686
	60,973,059	38,776	61,581	--	--	1,613,067	--	62,686,483
Property, plant and equipment:								
Land	287,549	--	--	--	--	--	--	287,549
Buildings and improvements	89,842,088	1,150,645	557,686	1,670	2,634,456	121,621	--	94,308,166
Equipment	177,709,110	5,970,379	840,854	1,058,109	2,147,088	338,857	--	188,064,397
Less accumulated depreciation	(236,509,671)	(5,489,858)	(928,604)	(1,051,748)	(2,529,839)	(236,166)	--	(246,745,886)
	31,329,076	1,631,166	469,936	8,031	2,251,705	224,312	--	35,914,226
	$ 155,439,138	$ 3,790,798	$ 4,927,550	$ 434,844	$ 5,242,566	$ 2,809,298	$ (476,152)	$ 172,168,042

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2014

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Liabilities and Net Assets								
Current Liabilities								
Accounts payable and accrued expenses	$ 21,414,080	$ 523,448	$ 519,922	$ 12,854	$ 1,240,758	$ 87,858	$ (476,152)	$ 23,322,768
Salaries, wages, payroll taxes and amounts withheld from employees	7,138,794	--	215,139	--	1,051,000	1,436,967	--	9,841,900
Due to third-party reimbursement agencies	4,171,981	--	--	--	--	--	--	4,171,981
Current portion of CHEFA obligations	493,776	--	--	--	--	--	--	493,776
Current portion of notes payable and capital lease obligations	416,447	--	--	--	45,258	--	--	461,705
Due to (from) affiliates	2,916,986	--	--	(62,523)	(1,723,479)	(530,868)	--	600,116
Total Current Liabilities	36,552,064	523,448	735,061	(49,669)	613,537	993,957	(476,152)	38,892,246
Other Noncurrent Liabilities	25,163,807	--	--	--	191,170	--	--	25,354,977
CHEFA Obligations - less current portion	23,789,744	--	--	--	--	--	--	23,789,744
Notes Payable and Capital Lease Obligations - less current portion	404,144	--	--	--	34,840	--	--	438,984
Net Assets								
Unrestricted	11,890,055	2,091,104	2,725,118	411,836	4,403,019	1,815,341	--	23,336,473
Temporarily restricted	8,729,527	--	--	--	--	--	--	8,729,527
Permanently restricted	48,909,797	--	--	--	--	--	--	48,909,797
Total Net Assets Excluding Noncontrolling Interests	69,529,379	2,091,104	2,725,118	411,836	4,403,019	1,815,341	--	80,975,797
Noncontrolling Interests	--	1,176,246	1,467,371	72,677	--	--	--	2,716,294
Total Net Assets	69,529,379	3,267,350	4,192,489	484,513	4,403,019	1,815,341	--	83,692,091
	$ 155,439,138	$ 3,790,798	$ 4,927,550	$ 434,844	$ 5,242,566	$ 2,809,298	$ (476,152)	$ 172,168,042

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2013

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Assets								
Current Assets								
Cash and cash equivalents	$ 19,142,392	$ 1,262,636	$ 1,706,736	$ 359,845	$ 1,317,437	$ 204,377	$ --	$ 23,993,423
Restricted cash	4,519,908	--	--	--	--	--	--	4,519,908
Short-term investments	--	--	472,637	--	--	--	--	472,637
Patient accounts receivable, net	25,010,738	751,229	1,842,494	352	1,952,597	430,068	(546,352)	29,441,126
Grants and other receivables	3,065,683	--	--	--	503,555	185,477	(52,191)	3,702,524
Inventories of supplies	3,416,317	--	--	--	162,966	2,312	--	3,581,595
Prepaid insurance and other expenses	1,291,734	--	71,843	4,686	80,404	122,798	--	1,571,465
Total Current Assets	56,446,772	2,013,865	4,093,710	364,883	4,016,959	945,032	(598,543)	67,282,678
Other Assets								
Funds held in trust by others	44,960,039	--	--	--	--	--	--	44,960,039
Long-term investments	10,713,229	42,426	59,040	--	--	--	--	10,814,695
Board-designated endowment funds	3,193,664	--	--	--	--	--	--	3,193,664
Other receivables	171,972	--	--	--	--	--	--	171,972
Goodwill	200,500	--	--	--	--	1,613,067	--	1,813,567
CHEFA obligations issue expense, less amortization	282,676	--	--	--	--	--	--	282,676
	59,522,080	42,426	59,040	--	--	1,613,067	--	61,236,613
Property, plant and equipment:								
Land	287,549	--	--	--	--	--	--	287,549
Buildings and improvements	89,664,119	1,150,646	488,740	--	2,634,456	114,371	--	94,052,332
Equipment	176,657,750	5,970,380	766,531	1,134,076	2,040,925	342,599	--	186,912,261
Construction in progress	73,654	--	--	--	--	--	--	73,654
Less accumulated depreciation	(229,493,366)	(5,279,792)	(822,193)	(1,113,060)	(1,999,154)	(182,454)	--	(238,890,019)
	37,189,706	1,841,234	433,078	21,016	2,676,227	274,516	--	42,435,777
	$ 153,158,558	$ 3,897,525	$ 4,585,828	$ 385,899	$ 6,693,186	$ 2,832,615	$ (598,543)	$ 170,955,068

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2013

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Liabilities and Net Assets								
Current Liabilities								
Accounts payable and accrued expenses	$ 20,802,742	$ 348,614	$ 479,401	$ 19,215	$ 502,553	$ 24,245	$ (598,543)	$ 21,578,227
Salaries, wages, payroll taxes and amounts withheld from employees	5,298,046	--	159,713	--	505,210	1,432,042	--	7,395,011
Due to third-party reimbursement agencies	2,969,391	--	--	--	--	--	--	2,969,391
Current portion of CHEFA obligations	472,136	--	--	--	--	--	--	472,136
Current portion of notes payable and capital lease obligations	405,496	--	--	--	289,053	--	--	694,549
Due to (from) affiliates	1,795,348	--	--	(3,634)	690,250	(439,013)	--	2,042,951
Total Current Liabilities	31,743,159	348,614	639,114	15,581	1,987,066	1,017,274	(598,543)	35,152,265
Other Noncurrent Liabilities	21,482,020	--	--	--	331,487	--	--	21,813,507
CHEFA Obligations - less current portion	24,283,520	--	--	--	--	--	--	24,283,520
Notes Payable and Capital Lease Obligations - less current portion	820,591	--	--	--	31,977	--	--	852,568
Net Assets								
Unrestricted	18,667,399	2,271,303	2,565,364	314,770	4,342,656	1,815,341	--	29,976,833
Temporarily restricted	8,409,794	--	--	--	--	--	--	8,409,794
Permanently restricted	47,752,075	--	--	--	--	--	--	47,752,075
Total Net Assets Excluding Noncontrolling Interests	74,829,268	2,271,303	2,565,364	314,770	4,342,656	1,815,341	--	86,138,702
Noncontrolling Interests	--	1,277,608	1,381,350	55,548	--	--	--	2,714,506
Total Net Assets	74,829,268	3,548,911	3,946,714	370,318	4,342,656	1,815,341	--	88,853,208
	$ 153,158,558	$ 3,897,525	$ 4,585,828	$ 385,899	$ 6,693,186	$ 2,832,615	$ (598,543)	$ 170,955,068

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2014

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Unrestricted Revenues								
Net patient service revenues	$ 212,319,638	$ 4,424,791	$ 11,147,032	$ --	$ 16,873,540	$ 6,530,662	$ (2,459,349)	$ 248,836,314
Provision for (bad debts) recoveries	(3,692,986)	14,875	(108,185)	1,691	(518,641)	(133,571)	--	(4,436,817)
Net patient service revenues less provision for bad debts	208,626,652	4,439,666	11,038,847	1,691	16,354,899	6,397,091	(2,459,349)	244,399,497
Other operating revenues	2,671,751	--	1,039	163,293	4,595,487	1,762,014	(4,996,755)	4,196,829
Net assets released from restrictions	5,542,491	--	--	--	--	--	--	5,542,491
	216,840,894	4,439,666	11,039,886	164,984	20,950,386	8,159,105	(7,456,104)	254,138,817
Operating Expenses								
Salaries	83,908,937	727,282	6,832,163	--	17,793,489	8,789,526	--	118,051,397
Employee benefits	23,614,397	60,000	1,345,857	--	3,210,651	1,148,898	--	29,379,803
Supplies and other	100,656,298	1,916,231	1,756,019	44,660	7,534,825	1,286,065	(7,456,104)	105,737,994
Depreciation	6,921,086	213,716	110,717	6,034	531,675	77,732	--	7,860,960
Interest and amortization	1,352,572	--	--	--	32,415	--	--	1,384,987
	216,453,290	2,917,229	10,044,756	50,694	29,103,055	11,302,221	(7,456,104)	262,415,141
Income (Loss) from Operations	387,604	1,522,437	995,130	114,290	(8,152,669)	(3,143,116)	--	(8,276,324)
Nonoperating Gains								
Unrestricted gifts and bequests	1,240,261	--	--	--	--	--	--	1,240,261
Investment income	1,819,310	--	21,378	--	--	--	--	1,840,688
	3,059,571	--	21,378	--	--	--	--	3,080,949
Excess (Deficiency) of Revenues Over Expenses Before Changes in Net Unrealized Gains on Investments	3,447,175	1,522,437	1,016,508	114,290	(8,152,669)	(3,143,116)	--	(5,195,375)
Changes in Net Unrealized Gains on Investments	76,602	--	16,225	--	--	--	--	92,827
Excess (Deficiency) of Revenues Over Expenses	3,523,777	1,522,437	1,032,733	114,290	(8,152,669)	(3,143,116)	--	(5,102,548)
Less Excess of Revenue over Expenses Attributable to Noncontrolling Interests	--	--	--	--	--	--	(926,677)	(926,677)
Excess (Deficiency) of Revenues Over Expenses Attributable to Controlling Interest	$ 3,523,777	$ 1,522,437	$ 1,032,733	$ 114,290	$ (8,152,669)	$ (3,143,116)	$ (926,677)	$ (6,029,225)

See independent auditors' report on other financial information.

THE WATERBURY HOSPITAL AND SUBSIDIARIES

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2013

	The Waterbury Hospital	Greater Waterbury Imaging Center Limited Partnership	Access Rehab Centers, LLC	Imaging Partners, LLC	Alliance Medical Group, Inc.	Cardiology Associates of Greater Waterbury, LLC	Eliminations	Consolidated
Unrestricted Revenues								
Net patient service revenues	$ 218,481,776	$ 4,496,888	$ 10,608,492	$ 172,403	$ 16,720,615	$ 6,426,998	$ (2,194,060)	$ 254,713,112
Provision for bad debts	(10,783,760)	29,929	(21,275)	--	(384,485)	(207,080)	--	(11,366,671)
Net patient service revenues less provision for bad debts	207,698,016	4,526,817	10,587,217	172,403	16,336,130	6,219,918	(2,194,060)	243,346,441
Other operating revenues	3,615,057	--	1,182	6,347	4,425,680	1,644,871	(4,483,169)	5,209,968
Net assets released from restrictions	5,419,591	--	--	--	--	--	--	5,419,591
	216,732,664	4,526,817	10,588,399	178,750	20,761,810	7,864,789	(6,677,229)	253,976,000
Operating Expenses								
Salaries	84,495,149	694,748	6,034,037	--	16,932,997	8,519,069	--	116,676,000
Employee benefits	25,316,268	85,023	1,245,184	--	3,120,845	1,146,177	--	30,913,497
Supplies and other	94,673,089	1,926,379	2,353,046	97,435	6,696,550	1,178,486	(6,677,229)	100,247,756
Depreciation	7,674,744	298,106	103,183	11,235	658,908	75,386	--	8,821,562
Interest and amortization	1,011,579	--	--	--	37,776	--	--	1,049,355
	213,170,829	3,004,256	9,735,450	108,670	27,447,076	10,919,118	(6,677,229)	257,708,170
Income (Loss) from Operations	3,561,835	1,522,561	852,949	70,080	(6,685,266)	(3,054,329)	--	(3,732,170)
Nonoperating Gains								
Unrestricted gifts and bequests	217,275	--	--	--	--	--	--	217,275
Investment income	1,722,250	--	15,173	--	--	--	--	1,737,423
	1,939,525	--	15,173	--	--	--	--	1,954,698
Excess (Deficiency) of Revenues Over Expenses Before Changes in Net Unrealized Gains on Investments	5,501,360	1,522,561	868,122	70,080	(6,685,266)	(3,054,329)	--	(1,777,472)
Changes in Net Unrealized Gains on Investments	233,353	--	34,882	--	--	--	--	268,235
Excess (Deficiency) of Revenues Over Expenses	5,734,713	1,522,561	903,004	70,080	(6,685,266)	(3,054,329)	--	(1,509,237)
Less Excess of Revenue over Expenses Attributable to Noncontrolling Interests	--	--	--	--	--	--	(874,685)	(874,685)
Excess (Deficiency) of Revenues Over Expenses Attributable to Controlling Interest	$ 5,734,713	$ 1,522,561	$ 903,004	$ 70,080	$ (6,685,266)	$ (3,054,329)	$ (874,685)	$ (2,383,922)

See independent auditors' report on other financial information.

Form **990-T**

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

For calendar year 2013 or other tax year beginning OCT 1, 2013 , and ending SEP 30, 2014

▶ Information about Form 990-T and its instructions is available at *www.irs.gov/form990t.*

▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

OMB No. 1545-0687

2013

Open to Public Inspection for 501(c)(3) Organizations Only

Department of the Treasury
Internal Revenue Service

A ☐ Check box if address changed

B Exempt under section
☒ 501(C)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
THE WATERBURY HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
64 ROBBINS STREET

City or town, state or province, country, and ZIP or foreign postal code
WATERBURY, CT 06708

D Employer identification number (Employees' trust, see instructions.)
06-0665979

E Unrelated business activity codes (See instructions.)
621500 811000

C Book value of all assets at end of year
172168042.

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ SEE STATEMENT 1

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 3

J The books are in care of ▶ SCOTT BOWMAN Telephone number ▶ 203-573-7333

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales 2,213,525. b Less returns and allowances 1,651,756. c Balance ▶	1c	561,769.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	561,769.		561,769.
4a	Capital gain net income (attach Form 8949 and Schedule D)	4a			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from partnerships and S corporations (attach statement)	5			
6	Rent income (Schedule C)	6			
7	Unrelated debt-financed income (Schedule E)	7			
8	Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10	Exploited exempt activity income (Schedule I)	10			
11	Advertising income (Schedule J)	11			
12	Other income (See instructions; attach schedule.)	12			
13	**Total.** Combine lines 3 through 12	13	561,769.		561,769.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.)

(Except for contributions, deductions must be directly connected with the unrelated business income.)

14	Compensation of officers, directors, and trustees (Schedule K)			14	
15	Salaries and wages			15	104,373.
16	Repairs and maintenance			16	
17	Bad debts			17	
18	Interest (attach schedule)			18	
19	Taxes and licenses			19	
20	Charitable contributions (See instructions for limitation rules.)			20	
21	Depreciation (attach Form 4562)	21	2,452.		
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	2,452.
23	Depletion			23	
24	Contributions to deferred compensation plans			24	
25	Employee benefit programs			25	29,374.
26	Excess exempt expenses (Schedule I)			26	
27	Excess readership costs (Schedule J)			27	
28	Other deductions (attach schedule) SEE STATEMENT 2			28	472,598.
29	**Total deductions.** Add lines 14 through 28			29	608,797.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	-47,028.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 4			31	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			32	-47,028.
33	Specific deduction (Generally $1,000, but see instructions for exceptions.)			33	1,000.
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32			34	-47,028.

Part III Tax Computation

35	**Organizations Taxable as Corporations.** See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here ▶ [X] **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ 50,000. (2) $ 25,000. (3) $ 9,925,000.		
b	Enter organization's share of: (1) Additional 5% tax (not more than $11,750) $ (2) Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from: [ ] Tax rate schedule or [ ] Schedule D (Form 1041) ▶	36	
37	**Proxy tax.** See instructions ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: [ ] Form 4255 [ ] Form 8611 [ ] Form 8697 [ ] Form 8866 [ ] Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2012 overpayment credited to 2013	44a			
b	2013 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: [ ] Form 2439 [ ] Form 4136 [ ] Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ [ ]			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2014 estimated tax** ▶ **Refunded** ▶			49	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

		Yes	No
1	At any time during the 2013 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
4a	Additional section 263A costs (att. schedule)	4a					
b	Other costs (attach schedule)	4b					
5	**Total.** Add lines 1 through 4b	5					

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

▶ Signature of officer Date ▶ PRESIDENT/TREASURER Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes [ ] No

Paid Preparer Use Only

Print/Type preparer's name: DOUGLAS FARRINGTON	Preparer's signature	Date: 8/10/15	Check [ ] if self-employed: PTIN P00370668
Firm's name ▶ MARCUM LLP			Firm's EIN ▶ 11-1986323
Firm's address ▶ CITY PLACE II 185 ASYLUM STREET HARTFORD, CT 06103			Phone no. 860-760-0600

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) **Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) **Total deductions.** Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property (a) Straight line depreciation (attach schedule)	3. (b) Other deductions (attach schedule)
(1)			
(2)			
(3)			
(4)			

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations 3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

Nonexempt Controlled Organizations

7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
			Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11 Enter here and on page 1, Part I, line 8, column (B).
Totals ▶			0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

Form **8868**
(Rev. January 2014)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

▶ **File a separate application for each return.**

▶ **Information about Form 8868 and its instructions is at** *www.irs.gov/form8868* .

OMB No. 1545-1709

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** and check this box ▶ ☐
- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** (on page 2 of this form).

Do not complete Part II unless you have already been granted an automatic 3-month extension on a previously filed Form 8868.

Electronic filing *(e-file)* . You can electronically file Form 8868 if you need a 3-month automatic extension of time to file (6 months for a corporation required to file Form 990-T), or an additional (not automatic) 3-month extension of time. You can electronically file Form 8868 to request an extension of time to file any of the forms listed in Part I or Part II with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, which must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit *www.irs.gov/efile* and click on *e-file for Charities & Nonprofits.*

Part I Automatic 3-Month Extension of Time. Only submit original (no copies needed).

A corporation required to file Form 990-T and requesting an automatic 6-month extension - check this box and complete Part I only ▶ ☒

All other corporations (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	**Enter filer's identifying number** Employer identification number (EIN) or
	THE WATERBURY HOSPITAL	06-0665979
	Number, street, and room or suite no. If a P.O. box, see instructions. 64 ROBBINS STREET	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. WATERBURY, CT 06708	

Enter the Return code for the return that this application is for (file a separate application for each return) ▶ 07

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ▶ SCOTT BOWMAN 64 ROBBINS STREET - WATERBURY, CT 06708
  Telephone No. ▶ 203-573-7333 Fax No. ▶
- If the organization does not have an office or place of business in the United States, check this box ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐ . If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until AUGUST 15, 2015 , to file the exempt organization return for the organization named above. The extension is for the organization's return for:
▶ ☐ calendar year _____ or
▶ ☒ tax year beginning OCT 1, 2013 , and ending SEP 30, 2014 .

2 If the tax year entered in line 1 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

3a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a	$ 0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	3b	$ 0.
c	**Balance due.** Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c	$ 0.

Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

FORM 990-T DESCRIPTION OF ORGANIZATION'S PRIMARY UNRELATED BUSINESS ACTIVITY STATEMENT 1

NONPATIENT LABORATORY SERVICES AND IMAGING REPAIR & MAINTENANCE

TO FORM 990-T, PAGE 1

FORM 990-T OTHER DEDUCTIONS STATEMENT 2

DESCRIPTION	AMOUNT
SUPPLIES	311,446.
INDIRECT COSTS	161,152.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	472,598.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 3

CORPORATION'S NAME	IDENTIFYING NO
GREATER WATERBURY HEALTH NETWORK, INC.	22-2572044

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/13	26,894.	0.	26,894.	26,894.
NOL CARRYOVER AVAILABLE THIS YEAR			26,894.	26,894.

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T
Connecticut Unrelated Business Income Tax Return

2013

Complete this return in blue or black ink only.

Enter Income Year Beginning ▶ OCTOBER 1 , 2013, and Ending ▶ SEPTEMBER 30, 2014

Taxpayer (Please type or print)

Organization name *(please type or print)*: THE WATERBURY HOSPITAL

Address Number and street PO Box: 64 ROBBINS STREET

City or town State ZIP code: WATERBURY, CT 06708

CT Tax Registration Number

DRS use only - - 20

Federal Employer ID Number (FEIN): 06-0665979

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) **Return status:** ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: NONPATIENT LABORATORY SERVICES AND IMAGING
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut:

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2013 federal Form 990-T, Part II, Line 34	1	-47,028	00
2. Federal net operating loss deduction from 2013 federal Form 990-T, Part II, Line 31	2		00
3. Federal deduction for Connecticut tax on unrelated business taxable income	3		00
4. **Total:** Add Lines 1, 2, and 3	4	-47,028	00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income	5		00
6. Unrelated business taxable income: Subtract Line 5 from Line 4	6	-47,028	00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3**	1	-47,028	00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places	2		
3. Connecticut unrelated business taxable income: Line 1 **or** Line 1 multiplied by Line 2	3	-47,028	00
4. Operating loss carryover from *Schedule B*, Line 14 on page 2	4		00
5. Income subject to tax: Subtract Line 4 from Line 3	5	-47,028	00
6. **Tax:** Multiply Line 5 by 7.5% (.075)	6		00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions	1		00
2. *Reserved for future use*	2		
3. Total Tax: Enter the amount from Line 1	3		00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1**	4		00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0."	5	0	00
6a. Paid with application for extension from **Form CT-990T EXT**	6a		00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC, & ESD**	6b		00
6c. Overpayment from prior year	6c		00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c	6		00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5	7	0	00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ CT-1120I Interest ▶ (8c) _____	8		00
9. Amount to be credited to 2014 estimated tax ▶ (9a) Refunded ▶ (9b)	9		00

For a faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8	10	0	00

Visit the DRS website at www.ct.gov/DRS **www.ct.gov/TSC** to pay electronically. Taxpayer Service Center (TSC)

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here

Name of officer or fiduciary *(print)*: DARLENE STROMSTAD

Signature of officer or fiduciary:

Date:

Officer's email address *(print)*:

Title: PRESIDENT/TREASURER

Telephone number: (203)573-6000

May DRS contact the preparer shown below about this return? See instructions. ☒ Yes ☐ No

Keep a copy of this return for your records.

Paid preparer's signature:

Date: 8/10/15

Preparer's SSN or PTIN: P00370668

Firm's name and address: MARCUM LLP
CITY PLACE II 185 ASYLUM STREET
HARTFORD, CT 06103

FEIN: 11-1986323

Telephone number: 860-760-0600

1019

341901 12-04-13

Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut	Column B Everywhere	Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories	00	00	
	(b) Tangible property	00	00	
	(c) Real property	00	00	
	(d) Capitalized rent	00	00	
	1. Total	00	00	
Receipts	2. (a) Sales of tangibles	00	00	
	(b) Services	00	00	
	(c) Rentals	00	00	
	(d) Other	00	00	
	2. Total	00	00	
Wages, salaries, and other compensation	**3. Total**	00	00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.			
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.			

Schedule B - Connecticut Apportioned Operating Loss Carryover Applied to 2013

1. 2000 Connecticut net operating loss available for use in 2013	1.		00
2. 2001 Connecticut net operating loss available for use in 2013	2.		00
3. 2002 Connecticut net operating loss available for use in 2013	3.		00
4. 2003 Connecticut net operating loss available for use in 2013	4.		00
5. 2004 Connecticut net operating loss available for use in 2013	5.		00
6. 2005 Connecticut net operating loss available for use in 2013	6.		00
7. 2006 Connecticut net operating loss available for use in 2013	7.		00
8. 2007 Connecticut net operating loss available for use in 2013	8.		00
9. 2008 Connecticut net operating loss available for use in 2013	9.		00
10. 2009 Connecticut net operating loss available for use in 2013	10.		00
11. 2010 Connecticut net operating loss available for use in 2013	11.		00
12. 2011 Connecticut net operating loss available for use in 2013	12.		00
13. 2012 Connecticut net operating loss available for use in 2013	13.	25,894	00
14. **Total:** Add Lines 1 through 13. Enter here and on *Computation of Tax*, Line 4	14.	25,894	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.	-47,028	00
2. Add back specific deduction from 2013 federal Form 990-T, Part II, Line 33	2.	1,000	00
3. Subtotal: Add Line 1 and Line 2	3.	-46,028	00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2013 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.	-46,028	00

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T EXT

Application for Extension of Time to File Unrelated Business Income Tax Return

See instructions. Complete this return in blue or black ink only.

2013

Enter Income Year Beginning ▶ OCT 1 , 2013, and Ending ▶ SEP 30, 2014

Taxpayer (Please type or print)		
Organization name *(please type or print)*	THE WATERBURY HOSPITAL	**CT Tax Registration Number** ▶
Address — Number and street — PO Box	64 ROBBINS STREET	**DRS use only** ▶ - - 20
City or town — State — ZIP code	WATERBURY, CT 06708	**Federal Employer ID Number (FEIN)** ▶ 06-0665979

Request for six-month extension of time to file Form CT-990T only

Enter above the beginning and ending dates of the organization's income year, Connecticut Tax Registration Number, and FEIN.

Check type of organization: [X] Corporation [ ] Domestic trust [ ] Foreign trust [ ] Other

An application for an extension to file **Form CT-990T**, with payment of tax tentatively believed to be due, must be submitted whether or not an application for federal extension has been approved.

I request a **six-month extension** of time to file **Form CT-990T**, *Connecticut Unrelated Business Income Tax Return*, for calendar year 2013, or until 08/17/15 for fiscal year ending 09/30/14 .

A federal extension will be requested on federal Form 8868, Application for Extension of Time to File an Exempt Organization Return, for calendar year 2013, or fiscal year beginning OCTOBER 1 , 2013, and ending SEPTEMBER 30,2014 . [X] Yes [ ] No

If **No,** the reason for the Connecticut extension is _____

Notification will be sent only if extension request is denied

Tentative Return

Computation						
1.	Tentative amount of tax due for this income year, including surtax if applicable. See instr.			1.		00
2.	*Reserved for future use*			2.		
3.	Total amount of tax due for this income year: Enter amount from Line 1			3.		00
4a.	Tax credits	4a	00			
4b.	Payments of estimated tax	4b	00			
4c.	Overpayment from prior year	4c	00			
4.	Total tax credits and payments: Add Lines 4a, 4b, and 4c			4.		00
5.	**Balance due with this return:** Subtract Line 4 from Line 3 ▶			5.	0	00

Make check payable to **Commissioner of Revenue Services.** Write the organization's Connecticut Tax Registration Number and "2013 Form CT-990T EXT" on the check and attach it to the return.

Mail this return to: Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014

Visit the DRS **Taxpayer Service Center (TSC)** at **www.ct.gov/TSC** to pay this return electronically. www.ct.gov/DRS TSC Taxpayer Service Center

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Name of officer or fiduciary *(print)*	Signature of officer or fiduciary	Date

Officer's email address *(print)*

Title	Telephone number	
Paid preparer's signature Patricia Tate	Date 2/10/15	Preparer's SSN or PTIN P01325330
Firm's name and address MARCUM LLP CITY PLACE II 185 ASYLUM STREET HARTFORD, CT 06103	FEIN 11-1986323	Telephone number 860-549-8500

1019 341911 12-04-13

EXHIBIT Q58-1 - PMH HOSPITAL ACQUISITIONS

Nix Health System

Texas – San Antonio

- Nix Health System
  - Acute Care Hospital
  - Rural Acute Care Hospital
  - Psychiatric Hospital
  - Specialty Hospital
  - 19 Primary and Specialty Clinics
  - Medical Groups Under Development
  - Centers of Excellence:
    - Behavioral/ Psychiatric Center of Excellence
    - Orthopedic Surgery of Excellence
    - Bariatric Surgery Of Excellence

01405

Texas - Nix Health

- **Transaction completed on 2/1/12**
  - First Entry in Texas Market for Prospect Medical

- **Accomplishments Since Nix Acquisition**
  - Formed a Medical Group
  - Forming a Multi-Specialty IPA – Integration with Behavioral Health
  - Expanded Behavioral Health services with addition of a 45 bed facility
  - Expanded Hospital-Based Outpatient Clinics
  - Purchase of Rural Hospital expanding the System
  - Converted Urgent Care Center to an Emergency Room
  - Entered into Risk Contracting with Major Insurers
  - Measurable Improvements in Quality Metrics

Prospect CharterCare Hospitals - RI

Our Lady of Fatima Hospital, a 278-bed acute care facility, is RI's only Catholic sponsored hospital providing an array of medical and surgical services.

Roger Williams Medical Center is a 220-bed acute care hospital and academic teaching and research affiliate of Boston University School of Medicine.

Elmhurst Extended Care is RI's only long-term facility affiliated with a hospital system and offers short-term, long-term and specialized elder care.

St. Joseph Health Center is a network of primary care programs and specialty services for underserved children and families.

Prospect CharterCare – Record of Performance

Entrance into Market

- Acquired system June 2014 (Two hospitals / Specialty Health Center / Nursing Home)

Project Commitments 2015 ($20M)

- Cancer Center
- Digestive Diseases Center
- Emergency Department
- Physician Practice Purchases

Proposed Service Lines

- OB
- Cardiac Cath

Model Implementation

- Quickly cleared regulatory hurdles to implement risk taking model
- Developed an IPA and recruited 105 PCPs / 270 specialists
- Negotiated risk contract with largest payer in state
- Medicare Select narrow network product with largest payer
- Went from 0 to 6,500 Medicare Advantage lives under population health management
- Grew from 20 to 81 providers
- $24M financial turnaround

What's Next – Road Ahead

- Coordinated Care Pilot Program accepted by State. Projected to carve costs out of State budget and generate savings to RI of $18M/3 years.
- A working model for Coordinated Care in the North East that can be used for further development
- Recognition by State's healthcare and political leaders for ability to transform the Healthcare Delivery Model

Bellflower and Tustin Hospitals

- **Transaction completed in May 2014**
  - Tustin Hospital - 177 Bed Facility
  - Bellflower - 80 Bed Facility

Both Hospitals had been closed for 1 year by the previous owner.

- **Accomplishments:**
  - Tustin:
    - Re-opening of Acute Care and Emergency Services.
    - Opened an Urgent Care
  - Bellflower:
    - Initial services include a 32 bed Behavioral unit.
    - Working with the community and local officials on a strategic plan for additional services.

01409