

ORIGINAL

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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS



GREATER WATERBURY HEALTH NETWORK, INC.  
AND PROSPECT MEDICAL HOLDINGS, LLC

GREATER WATERBURY HEALTH NETWORK, INC.  
PROPOSED ASSET PURCHASE BY  
PROSPECT MEDICAL HOLDINGS, INC.

DOCKET NOS. 15-32017-486 AND 15-486-02

MAY 3, 2016

1:03 P.M.

63 GRAND STREET  
WATERBURY, CONNECTICUT

POST REPORTING SERVICE  
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HEARING RE: GREATER WATERBURY HEALTH & PROSPECT MEDICAL  
MAY 3, 2016

1 . . .Verbatim proceedings of a hearing  
2 before the State of Connecticut, Department of Public  
3 Health, Office of Health Care Access, in the matter of  
4 Greater Waterbury Health Network, Inc. and Prospect  
5 Medical Holdings, LLC, Greater Waterbury Health Network,  
6 Inc. proposed asset purchase by Prospect Medical  
7 Holdings, Inc., held at 63 Grand Street, Waterbury,  
8 Connecticut, on May 3, 2016 at 1:03 p.m. . . .

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10  
11

12 HEARING OFFICER KEVIN HANSTED: Good  
13 afternoon, everyone. This public hearing before the  
14 Office of the Attorney General and Office of Health Care  
15 Access, identified by Docket Nos. 15-32017-486 and 15-  
16 486-02, is being held on May 3, 2016 to consider Greater  
17 Waterbury Health Network, Inc. and Prospect Medical  
18 Holdings, LLC application for the Greater Waterbury  
19 Health Network, Inc. proposed asset purchase by Prospect  
20 Medical Holdings, Inc.

21 The hearing is part of the procedure under  
22 what is commonly referred to as the Conversion Statute,  
23 which requires the Commissioner of the Department of  
24 Public Health and the Attorney General to evaluate any

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1 proposal, which would convert a non-profit Connecticut  
2 hospital to a for-profit entity.

3 For OHCA's purposes, this public hearing  
4 is being held pursuant to Connecticut General Statutes,  
5 Section 19a-639a and 19a-486e, and will be conducted as a  
6 contested case, in accordance with the provisions of  
7 Chapter 54 of the Connecticut General Statutes.

8 My name is Kevin Hansted, and I have been  
9 designated as the Hearing Officer for the Office of  
10 Health Care Access for this evening's hearing.

11 The staff members assigned to this case  
12 with me are Kimberly Martone, Director of Operations,  
13 Steven Lazarus and Carmen Cotto. The hearing is being  
14 recorded by Post Reporting Services.

15 In making its decision, OHCA will make its  
16 determination on this application pursuant to Sections  
17 19a-486d and 19a-639 of the Connecticut General Statutes.

18 Specifically, OHCA will consider the  
19 following; whether the effected community will be assured  
20 of continued access to affordable health care, whether  
21 the purchaser has made a commitment to provide health  
22 care to the uninsured and underinsured, whether  
23 safeguards are in place to avoid a conflict of interest  
24 in patient referrals, and OHCA will take into

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1 consideration and make written findings concerning each  
2 of the statutory Certificate of Need guidelines and  
3 principles.

4 Generally speaking, there was a public  
5 need, access, quality and financial feasibility of the  
6 project.

7 Greater Waterbury Health Network, Inc. and  
8 Prospect Medical Holdings, LLC have been designated as  
9 parties in this proceeding.

10 At this time, I'll hand it over to Deputy  
11 Attorney General Perry Zinn Rowthorn for some additional  
12 comments.

13 MR. PERRY ZINN ROWTHORN: Thank you,  
14 Kevin. As Kevin mentioned, I'm Perry Zinn Rowthorn. I'm  
15 the Deputy Attorney General for the State of Connecticut.  
16 I've been designated by Attorney General George Jepsen as  
17 the Hearing Officer for this proceeding.

18 I want to thank all of you for being here,  
19 the Applicants, the witnesses, the members of the public  
20 and public officials, whom we'll hear from today.

21 I want to take a minute or two to talk  
22 about what this proceeding is, put it in the context of  
23 our review of the pending application.

24 Before I do that, I do want to say a

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1 special thank you to the members of the public, who are  
2 here today. We know that the Greater Waterbury Health  
3 Network and Waterbury Hospital are important assets in  
4 your community, and many of you have strong personal  
5 bonds with the hospital, so we take that seriously, hence  
6 our presence here today.

7 I know there's a lot of, also, a lot of  
8 employees. I see white coats and hospital scrubs here  
9 today, so we are anxious, as well, to hear from you, so  
10 your input is valuable to us.

11 We are, as Attorney Hansted mentioned,  
12 conducting this hearing jointly with OHCA, but we do have  
13 a different and distinct role in reviewing the  
14 transaction, a different focus and different criteria.

15 Our role here is defined and limited by  
16 the Hospital Conversion Act, Connecticut General Statute  
17 19a-486.

18 That Act reflects the Attorney General's  
19 traditional role in protecting the public interest and  
20 charitable assets and insuring that monies and properties  
21 committed to a charitable purpose are safeguarded and  
22 used appropriately.

23 Non-profit hospitals and hospital systems,  
24 like Greater Waterbury Health Network, hold their assets

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1 for essentially a charitable purpose, providing health  
2 care, not for generating profits for shareholders or  
3 owners, and, in that way, not-for-profit hospital systems  
4 are different than for-profit hospital systems.

5 The administrators of not-for-profit  
6 hospital systems are the stewards of its charitable  
7 assets with a responsibility to take good care of those  
8 assets.

9 The law does not prohibit non-profit  
10 hospitals from converting to for-profit status, but when  
11 one seeks to do so, as here, the Attorney General is  
12 charged with ensuring that the non-profit hospital is  
13 meeting its obligations of care for the charitable  
14 assets, and we look at three things, in particular.

15 We look at the process. We ensure that  
16 the process leading to the sale was responsible. We ask  
17 were the hospital administrators careful in deciding to  
18 sell and choosing a buyer and negotiating a transaction?

19 We look at the terms of the sale to make  
20 sure they are fair. Will the hospital get the fair  
21 market value? Will it get fair market value for its  
22 assets? And then we look at the proceeds of the deal  
23 after the sale. Will the charitable assets continue to  
24 be used for health-related purposes?

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1                   We need to ensure that those assets are  
2 protected from being used for the for-profit making  
3 purposes of the new hospital system.

4                   Because the Attorney General must remain  
5 focused throughout his review on the charitable assets,  
6 his review and our decision for the most part do not  
7 focus on the running of the for-profit hospital after the  
8 transaction.

9                   Issues relating to the operation of the  
10 new hospital entity, as it relates to access to health  
11 care services, are within OHCA's purview.

12                   Today's hearing is a very important part,  
13 but just one part of a review that has been ongoing for  
14 months. We'll take testimony and evidence, and we'll  
15 hear public input.

16                   We'll ask some questions, but don't  
17 assume, if we don't ask questions on a topic, that the  
18 topic is unimportant to us. We have received and  
19 reviewed thousands of pages of documents already, and  
20 we've asked many follow-up questions, and all of those  
21 materials are available on the Attorney General's  
22 website, [www.ct.gov/ag](http://www.ct.gov/ag).

23                   Your input is important to this review.  
24 All the information we receive today will become part of

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1 the official record of our review.

2 We'll do our best to accommodate everyone,  
3 who wants to speak. We'll also be taking comments in  
4 writing, and those comments will also be included in the  
5 official record.

6 We have sheets I think that many of you  
7 saw on your way in on the tables for those members of the  
8 public, who want to sign up to be heard, so, if you are  
9 interested, please do sign up.

10 Let me say a word about what the end of  
11 this process looks like. Under the statute, the Attorney  
12 General must approve the transaction as it is, deny it,  
13 or approve it with conditions that relate to the purposes  
14 of the Conversion Act.

15 For the Attorney General, that would  
16 generally mean that any conditions would relate to the  
17 Attorney General's focus on the hospital's charitable  
18 assets and the future protection of those assets.

19 This is a joint hearing, as we've  
20 mentioned. Kevin and I are going to work together to  
21 move this along to cover as much business as we can. You  
22 can assume that, if either of us makes a ruling on an  
23 objection or a procedural point, that the ruling is for  
24 both offices, unless we state otherwise.



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1 I think there are sheets with the agenda  
2 for today, but let me just go through what you can expect  
3 this afternoon.

4 First, we'll hear Applicant's Direct  
5 testimony, so we'll hear, in essence, an overview of the  
6 transaction from the Applicants. We will then break, and  
7 then hear from members of the public, who have signed up  
8 or will sign up, then we will ask questions.

9 OHCA will ask questions first, and then,  
10 to the extent there are areas that remain uncovered, the  
11 Attorney General's Office will ask questions, then we'll  
12 hear closing remarks, and then we will adjourn.

13 So let me turn it back over to Kevin for  
14 some additional housekeeping before we get into opening  
15 statements.

16 Before I do that, I want to introduce the  
17 staff from the Attorney General's Office, who is working  
18 on this transaction.

19 To my immediate left is Henry Salton,  
20 Assistant Attorney General, who heads our Health and  
21 Education Department, and next to him is Gary Hawes,  
22 Assistant Attorney General in our Special Litigation and  
23 Charities Unit. We also have with us Cheryl Turner, who  
24 is a paralegal specialist, who has been helping with the

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1 transaction. Cheryl is over here.

2 So, with that, thank you very much.

3 Kevin?

4 HEARING OFFICER HANSTED: Thank you,  
5 Perry. At this time, I'll ask staff to read into the  
6 record those documents already appearing in the Table of  
7 the Record in this matter. All documents have been  
8 identified in the Table of the Record for reference  
9 purposes. Mr. Lazarus?

10 MR. STEVEN LAZARUS: Good afternoon.  
11 Steven Lazarus. For today's record, I would like to  
12 include Exhibits A through S, as listed on the Table of  
13 the Record, as well as we will be adding a new exhibit,  
14 Exhibit T. That is the copy of the Quality Assurance  
15 Commitment submitted by the Applicants this morning  
16 between Prospect Medical Holdings and Greater Waterbury  
17 Health Network.

18 We do have extra copies, in case some of  
19 you would like to review them.

20 HEARING OFFICER HANSTED: Thank you, Mr.  
21 Lazarus. Counsel, are there any objections?

22 MS. MICHELE VOLPE: No objections.  
23 Michele Volpe, legal counsel. I do want to note that,  
24 for the Table of Record, N, as in Nancy, it may be more

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1 appropriately placed in the Table of Record of the ECHN  
2 hearing. I think that may have been a support letter.

3 MR. LAZARUS: I believe that was rectified  
4 this morning.

5 MS. VOLPE: Okay.

6 MR. LAZARUS: So the updated or the  
7 revised Table of Record does not include that one.

8 MS. VOLPE: Okay.

9 MR. LAZARUS: That was an error on OHCA's  
10 part.

11 MS. VOLPE: And, so, the quality letter is  
12 in the Table of Record as S?

13 MR. LAZARUS: Exhibit T.

14 MS. VOLPE: Okay.

15 MR. LAZARUS: N was --

16 HEARING OFFICER HANSTED: N is now the  
17 request for legal notification?

18 MR. LAZARUS: Yeah, because we did get  
19 additional exhibits, which were the letters of support,  
20 last night, so I think that took the place of the N.

21 MS. VOLPE: That took the place of N?

22 MR. LAZARUS: Yeah.

23 MS. VOLPE: Okay. So the letters of  
24 support were the 119 pages?

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1 MR. LAZARUS: Yes.

2 MS. VOLPE: Okay. Great. Thank you.

3 HEARING OFFICER HANSTED: Attorney Volpe,  
4 do you have an updated Table of the Record? If not, we  
5 can provide you with one, and, if there are any other  
6 concerns, we can address it later in the hearing, if  
7 that's okay.

8 MS. VOLPE: No, I think they've been  
9 addressed. Thank you.

10 HEARING OFFICER HANSTED: Okay. As Perry  
11 started to mention earlier, for today's hearing, we will  
12 first hear from the Applicant for an overview of the  
13 project, then we will hear public comments on the  
14 proposal.

15 Out of deference to elected officials, we  
16 will call them first, and then we will turn to the sign-  
17 up sheet, which is provided outside the door on the  
18 table. And, again, any individuals, who wish to provide  
19 public comment, please sign up on the public sign-up  
20 sheet, just so we know who to call at the appropriate  
21 time.

22 Before we begin, would all the  
23 individuals, who are going to testify here this evening,  
24 please stand, raise your right hand, and be sworn in by

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1 the court reporter?

2 (Whereupon, the parties were duly sworn  
3 in.)

4 HEARING OFFICER HANSTED: Thank you, all.  
5 And would each of you, who have just taken the oath,  
6 please identify yourselves for the record? You might  
7 have to move up to one of the microphones, so it's picked  
8 up.

9 DR. CARL SHERTER: Dr. Carl Sherter.

10 HEARING OFFICER HANSTED: Thank you.

11 MS. SUSAN CORDEAU: Susan Cordeau,  
12 Director of Performance Improvement.

13 MS. DARLENE STROMSTAD: Darlene Stromstad.

14 MR. CARL CONTADINI: Carl Contadini.

15 DR. MITCHELL LEW: Mitchell Lew,  
16 President, Prospect Medical Holdings, and I'd like to  
17 adopt my pre-filed testimony.

18 HEARING OFFICER HANSTED: Thank you.

19 MR. STEVE ALEMAN: Steve Aleman, Chief  
20 Financial Officer, Prospect Medical Holdings, and I adopt  
21 my pre-filed testimony.

22 HEARING OFFICER HANSTED: Thank you.

23 MR. VON CROCKETT: Von Crockett, Senior  
24 Vice President for Corporate Development for Prospect

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1 Medical Holdings, and I adopt my pre-filed testimony.

2 HEARING OFFICER HANSTED: Thank you.

3 MS. DEBBIE BERRY: Debbie Berry. I'm the  
4 Chief Quality Officer for Prospect Medical.

5 MR. JON SPEES: I'm Jon Spees. I'm the  
6 Senior Vice President with Prospect Medical Holdings, and  
7 I adopt my pre-filed testimony.

8 MR. TOM REARDON: And I'm Tom Reardon,  
9 President of Prospect East.

10 HEARING OFFICER HANSTED: Thank you. And  
11 we have some other folks, who are sitting in the  
12 audience. If you would just come up one at a time,  
13 please?

14 MR. JIM MOYLAN: I'm Jim Moylan. I was  
15 the previous CFO of Waterbury Hospital up until last  
16 Friday, and I'm a consultant to Waterbury Hospital, and I  
17 adopt my pre-filed testimony.

18 HEARING OFFICER HANSTED: Thank you.

19 MS. SANDY IADAROLA: Sandy Iadarola. I'm  
20 the Chief Nursing Officer from Waterbury Hospital.

21 HEARING OFFICER HANSTED: Thank you.

22 DR. JOEY COSGRIFF: Dr. Joey Cosgriff.  
23 I'm the Medical Director of Performance Improvement.

24 MR. RICHARD KROPP: I'm Richard Kropp,

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1 Vice President of Human Resources.

2 HEARING OFFICER HANSTED: All right, thank  
3 you, everyone. And just a reminder, if you are  
4 testifying here today, before you initially testify,  
5 please just identify yourselves for the record, and if  
6 you have not already done so, please adopt your pre-filed  
7 testimony for the record.

8 At this time, we'll allow the Applicants  
9 to proceed with their presentation.

10 MR. CONTADINI: Thank you.

11 HEARING OFFICER HANSTED: You're welcome.

12 MR. CONTADINI: Carl Contadini, Chairman  
13 of the Board, Waterbury Health Network, and I would like  
14 to adopt my pre-filed testimony.

15 HEARING OFFICER HANSTED: Thank you.

16 MR. CONTADINI: Today, we're going to  
17 overview the process that got us to where we are today.  
18 I will then turn this over to Darlene Stromstad, who will  
19 give her viewpoints on today and future plans.

20 Sue Cordeau will give a presentation on  
21 performance improvement and Waterbury Hospital Medical  
22 staff involvement, Dr. Carl Sherter will talk in regards  
23 to the Transaction Committee, and representatives from  
24 Prospect will have their own program today.

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1 HEARING OFFICER HANSTED: Can everyone in  
2 the back of the room hear okay? Okay. All right.

3 MR. CONTADINI: It's been a long journey.  
4 Greater Waterbury Health Network began reviewing options  
5 for sustaining the organization more than 10 years ago.

6 In 2005, commissioned a study on the  
7 merger with St. Mary's Hospital. Those discussions went  
8 on in 2006 and 2007 between Greater Waterbury Health  
9 Network and St. Mary's Hospital.

10 In 2007, there was a draft OHCA report  
11 recommending consolidation of those two hospitals, and,  
12 in 2008, we were unable to reach agreement, and  
13 discussions ended at that time.

14 In 2009, Greater Waterbury Health Network  
15 defaulted on its CHFA bond covenants, and, in 2010, the  
16 Board engaged consultants to analyze projected capital  
17 needs. Anticipated cash would be depleted by 2015.

18 In 2011, the Board formed a task force to  
19 chart future course of Greater Waterbury Health Network,  
20 and we also, at that point in time, hired our new CEO.

21 In 2011, it was approximately February, we  
22 hired an investment banker, Cain Brothers, selected to  
23 lead the process to cast a net for the potential  
24 partners.



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1           The priority at that time, which still is  
2 today, is sustainability, high quality, accessible health  
3 care.

4           In 2011, two finalists were selected,  
5 Vanguard Health and LHP. In August of that year, LHP,  
6 which had an LOI with St. Mary's, was selected, based on  
7 its promise to build a new hospital, were continued on  
8 the merger of the two hospitals through 2011 and 2012,  
9 and, by August of 2012, LHP terminated relationships with  
10 both hospitals and left Connecticut.

11           At that same time, in August of '12,  
12 Greater Waterbury Health Network's Task Force regrouped,  
13 met with St. Mary's Hospital to explore possibilities to  
14 work together, and no further path was identified.

15           In the fall 2012, the task force, again,  
16 dove back into the marketplace, reaffirms the priority to  
17 provide sustainable health, high-quality accessible  
18 healthcare, with a commitment to invest in outpatient  
19 service strategy, physician recruitment and capital  
20 upgrades.

21           In the fall of 2012, two finalists  
22 interviewed, Vanguard Health and Prospect Medical  
23 Holdings. In October of '12, Vanguard Health was  
24 selected.

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1 August 2013, Vanguard announced a  
2 strategic alliance with Yale-New Haven Health Systems.  
3 October 2013, Tenet Health Care Purchases Vanguard.  
4 Tenet announced the inclusion of St. Mary's Hospital in  
5 the deal with two separate hospitals and Waterbury under  
6 one parent company.

7 In October of 2014, Greater Waterbury  
8 Health Network's public hearing. November of 2014,  
9 transaction approved, with over 70 conditions.

10 In December 2014, Tenet announced  
11 departure from Connecticut, and, in January 2015, in  
12 spite of political overtures, Tenet departed was final.

13 Greater Waterbury Health Network defines a  
14 two-part strategy at that point in time; try to rebuild  
15 our organization by simultaneously identifying potential  
16 partners.

17 In the spring of 2012, we identified a  
18 pool of potential partners and it was limited. I think  
19 we had two people of interest.

20 The LOI with Prospect Medical Holdings was  
21 announced. Greater Waterbury Health Network holds the  
22 first public hearing in August of 2015, and Greater  
23 Waterbury Health Network entered into a forbearance  
24 agreement with its bondholders in December 2012, '15.

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1 Overview of the transaction. Forty-five-  
2 million-dollar purchase price, subject to certain  
3 adjustments; cash, assumption of certain liabilities,  
4 such as pension plans.

5 Fifty-five-million-dollar capital  
6 commitment, subject to certain adjustments; facility  
7 improvements, equipment updates and development of  
8 coordinated care regional care model.

9 Included in the transaction substantially  
10 all of the assets, including the hospitals, physician  
11 practices, joint ventures and real estate.

12 Excluded were restricted funds, charitable  
13 assets, the child care center, the captive insurance,  
14 inactive entities and other certain liabilities.

15 Continuing operations in Waterbury  
16 Hospital, the continuing involvement of an Advisory Board  
17 that included community representatives, capital  
18 investments to improve facilities and equipment,  
19 physician recruitment and network, hire all of the  
20 employees and assume contracts, continuation of charity  
21 care and indigent care, establishment of community  
22 foundation to oversee certain charitable funds, and  
23 that's the transaction in general.

24 The community foundation, a new, totally

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1 independent foundation will be formed, hold or receive  
2 the benefits of certain charitable assets, receive the  
3 net proceeds of the sale, and no post-closing  
4 liabilities. Thank you.

5 MS. STROMSTAD: Good afternoon. I'm  
6 Darlene Stromstad. I used to be the new CEO of Waterbury  
7 Hospital. Now I'm the old CEO, and I adopt my pre-filed  
8 testimony.

9 It's good to see you again, and I thank  
10 you for your continued interest and attention to our  
11 organization.

12 I'm going to pick this up where we last  
13 left off, the winter of 2015. Mr. Contadini did a very  
14 thorough job of talking about the journey that brings us  
15 here today, so I want to talk about just the past year,  
16 since Tenet announced it was leaving Connecticut.

17 When that happened, our organization  
18 suffered deeply. After two years of effort, when the  
19 deal was called off last winter, our organization went  
20 into a depression. Employees left. Some doctors changed  
21 allegiances. Others invested in competitive surgery  
22 centers, and our confidence was shaken.

23 2015 was the most difficult financial year  
24 ever for Waterbury Hospital, and we've had a few, and it

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1 was also the most difficult for my career. We had to  
2 balance the challenge of running a hospital known for  
3 quality, which was suffering financially, while working  
4 on a deal to bring us long-term stability.

5 We have definitely learned a lot during  
6 our past transaction attempts and understood clearly that  
7 this time the key to our success was finding a partner  
8 with a strong likelihood of bringing a deal to close, as  
9 well as meeting all of our other priorities, and Prospect  
10 was that.

11 They understood the regulatory environment  
12 of the Northeast. They recognized the immediacy of our  
13 needs, but would invest for the long haul. There would  
14 be little to no disruption to our services or to our  
15 employees, and they would bring us a new model of payment  
16 and delivery, and they had success in neighboring Rhode  
17 Island.

18 I don't need to repeat what I said at  
19 previous hearings before or what you have heard from  
20 other hospitals over the last couple of years.

21 Our industry is changing dramatically, and  
22 our reimbursement has only gotten worse. There's  
23 enormous financial pressure being placed on hospitals  
24 like mine, those that are single, standalone, with a very

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1 challenging payer mix, and we are not immune to the  
2 requirement to adapt new payment and delivery systems.

3 As both a hospital company and a  
4 population health management company, Prospect brings the  
5 experience to position us to make the complicated move to  
6 a value-based delivery system, and their access to  
7 capital allows us to make the investment necessary to be  
8 a high-quality hospital for the long haul.

9 Waterbury Hospital. Maybe you think about  
10 us as the hospital on the hill, but we really are so much  
11 more than that. We have a very significant footprint in  
12 the Greater Waterbury area. These network affiliates  
13 combined that make up the Greater Waterbury Health  
14 Network.

15 Our issue is not one about volume. As you  
16 can see from our slides, each year, our employees have  
17 the opportunity to touch the lives of hundreds of  
18 thousands of people. Just this list alone on this slide  
19 totals more than 500,000. That's 500,000 patient  
20 encounters. That's half a million a year.

21 So as these numbers show, I am enormously  
22 proud that, in spite of our well-publicized financial  
23 challenges over the past few years, we continue to be the  
24 hospital of choice for much of our community.

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1                   Our past fiscal year, which ended  
2                   September 30, 2015, is a year best looked through one's  
3                   rearview mirror. The losses we suffered were devastating  
4                   to the hospital and very personally and professionally  
5                   humiliating and humbling, so I think it is very important  
6                   for you all to know that today we are financially and  
7                   operationally stable.

8                   That means we are at break even, which is  
9                   an enormous feat. It doesn't mean that we have capital  
10                  to invest in the future, but because of the hard work of  
11                  many of the employees, of doctors that work throughout  
12                  our network, many of them are here today, it's to their  
13                  credit.

14                  Last fall, our employees and employed  
15                  physicians accepted salary and benefit cuts to help us  
16                  gain solid footing once again.

17                  We asked for and received sacrifices from  
18                  our employees, our medical staff and our Union, and I am  
19                  pleased to say that all of those cuts have today been  
20                  restored, and our employees and our physicians have never  
21                  lost touch with our promise to our patients, that we  
22                  would keep them at the center of everything we do, in  
23                  spite of any distractions.

24                  Their sacrifices, as well as many, many

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1 other initiatives, have allowed us to dig ourselves out  
2 of a black hole, or a red hole, as it was, and I'm really  
3 proud of that, but it is simply not enough.

4 We do not have access to capital to be  
5 competitive and to remain sustainable for the long term.  
6 We have a proud history; 126 years of providing world  
7 class, high-quality health care in a teaching  
8 environment.

9 We care for some of the most at-risk  
10 people in the state of Connecticut, and we are enormously  
11 proud to do so, and this transaction will ensure that we  
12 are able to continue that.

13 Prospect's model will allow us to build  
14 stronger medical staff partnerships through our IPA.  
15 Already, we have more than 300 members. With the long  
16 history of population health management, they can teach  
17 us to become a leader in new delivery models that will be  
18 beneficial to the region we serve, and we'll be able to  
19 invest in equipment and outpatient services that will  
20 allow us to be more competitive and grow by attracting  
21 back the many patients, who have been lured away by  
22 larger, wealthier health care systems.

23 As you know, we've been at this for some  
24 time. Prospect helped us achieve the initial goals we



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1 set for our transaction several years ago;  
2 sustainability, accessibility and the ability to continue  
3 to deliver high-quality health care.

4 Waterbury Hospital has received many  
5 awards over the years for its high-quality health care.  
6 That is who we are, and that is who we want to remain.  
7 Therefore, when we learned of CMS violations at two of  
8 Prospect's California hospitals, we undertook additional  
9 due diligence and formed a special board quality  
10 committee that undertook a rigorous review.

11 We needed to ensure high-quality health  
12 care would be delivered by all Prospect hospitals,  
13 including ours, in the future.

14 So to talk to you further about this  
15 process is Susan Cordeau, our Director of Performance  
16 Improvement.

17 MS. CORDEAU: Thank you very much,  
18 Darlene. As Darlene stated, I'm Susan Cordeau. I'm the  
19 Director of Performance Improvement at Waterbury  
20 Hospital, and I was one of seven members that were part  
21 of this task force, and we had representation that  
22 included our Board, medical staff, nursing and the  
23 Quality Performance Improvement Departments.

24 The task force was empowered or

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1 established to review the immediate jeopardy CMS survey  
2 violations of the California-based hospitals owned by  
3 Prospect and, also, to review the corrective action plans  
4 to ensure that they went back into compliance on those  
5 violations. Dependent on the outcome of our review, we  
6 would make recommendations to our Board of Directors.

7 So the scope of our review, it was very  
8 broad, very deep. We requested from Prospect and they  
9 provided us the last three years of their CMS  
10 deficiencies for all of hospitals.

11 Each member of the task force received  
12 several binders of the violations of the documents that  
13 included the violations and their corrective action  
14 plans.

15 To ensure all members of this task force  
16 had a true understanding of the CMS regulatory process, I  
17 did provide the definitions of the CMS violations, which  
18 are standard, conditional, and then immediate jeopardy.

19 Obviously, we looked at everything very  
20 seriously, and then the areas of concern where we decided  
21 to focus were on the California hospitals, where there  
22 were three immediate jeopardy violations identified.

23 So, from there, we had long discussions,  
24 we reviewed, and we came up with a plan, and it was a

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1 four-part plan. First, we developed questions that we  
2 wanted to ask to Prospect Health Care. We requested a  
3 conference call with a Prospect Medical Holdings  
4 executive.

5 We asked for an on-site visit at  
6 CharterCARE in Rhode Island with their Quality and Risk  
7 Department, so we could get a sense for how they were  
8 doing, and then, fourth, some of our senior leadership  
9 actually went out to LA and toured Culver City, which was  
10 one of the hospitals that had an immediate jeopardy  
11 violation.

12 So our initial concerns. The task force,  
13 we were all very confident in the high-quality health  
14 care we provide at Waterbury Hospital. We're proactive  
15 in our approach at Waterbury. We use evidence-based  
16 practices. Our policies and procedures support the CMS  
17 conditions of participation and the Joint Commission  
18 standards.

19 We audit our compliance on these to make  
20 sure that we are maintaining compliance, and we report  
21 that throughout the hospital at the management level, the  
22 staff level, and at a performance improvement, so we're  
23 very transparent, so we knew we had a good plan in place.

24 So our concern became will that change?

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1 Will the quality of the Greater Waterbury Health Network  
2 be maintained?

3 Also, would there be adequate financial  
4 and human resources to ensure, for the Quality and Risk  
5 Departments, to ensure our future, that we could maintain  
6 this? Last, how does Prospect handle significant  
7 challenges?

8 So the specific issues identified in  
9 California hospitals, we came up with four concerns, four  
10 basic concerns; the pattern of the widespread ineffective  
11 sterilization processes, the issues of the temperature  
12 and humidity in the OR in some of the procedural rooms,  
13 the lack of leadership and governing body oversight, and  
14 a failure of the hospital to follow through on several of  
15 its corrective action plans.

16 So there is a typo in one of these, our  
17 results. So through our review, we identified there were  
18 three immediate jeopardy violations affected at two of  
19 the -- only two of the 14 Prospect hospitals.

20 During our conference call with Mr.  
21 Crockett, it became very clear that Prospect had a true  
22 understanding of the violations. They took things very  
23 seriously. They made a very big commitment, both  
24 financially and, also, to develop a very experienced

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1 quality team.

2 Senior leader, Mr. Crockett, was extremely  
3 transparent and very knowledgeable. He could answer  
4 every question about every violation, and it was very  
5 reassuring to all of us on the task force as we sat in  
6 that room.

7 He provided detailed explanations and  
8 plans for change. He shared with us the new corporate  
9 organizational structure, which included a Chief Quality  
10 Officer, and I'm happy to report that Dr. Cosgriff, who  
11 is the Medical Director of the Performance Improvement  
12 Department, and myself had the pleasure to meet Debbie  
13 yesterday, and we share common goals and visions, as far  
14 as quality.

15 They also hired a Chief Clinical Officer,  
16 Chief Nursing Officer, an Associated VP of Regulatory  
17 Affairs and Patient Safety, and east and west coast  
18 Regional Quality Officers.

19 We heard and we're very reassured by Mr.  
20 Crockett that quality needs to be controlled and will be  
21 controlled at the local level, with corporate oversight  
22 and support.

23 That same great experience was just shared  
24 when we went to Rhode Island. It was very reassuring.

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1 Their relationship with Prospect is enhanced. There are  
2 already robust quality and safety programs, and they  
3 shared with us that resources, both financially and with  
4 human resources, are consistently made available.

5 The processes are not difficult to get  
6 financial resources, and they already have a lot of  
7 corporate kind of -- what's the term I'm looking for?  
8 It's tough to be old, you know? You lose your train of  
9 thought. To their facility. They had already started to  
10 do major renovations to their facilities.

11 So, obviously, we came back as a task  
12 force, and we felt that the changes at Prospect we're  
13 able to make in a very short period of time reflected a  
14 commitment to quality and the availability of deep  
15 financial resources.

16 And, so, on April 13th, the task force met  
17 with the Board, our Board of Directors, and we went  
18 through the entire process that we did, and we made a  
19 proposal that the transaction with Prospect Medical  
20 Holdings move forward with recommendations, and that was  
21 unanimously approved by our Board of Directors.

22 And the recommendations have been  
23 memorialized in a quality assurance letter, and they  
24 maintain our current quality programs, continue Joint

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1 Commission accreditation, maintain our current reporting  
2 structure to a local CEO, with a dotted line relationship  
3 to the Chief Quality Officer, share evidence-based  
4 practices across the systems, and then provide adequate  
5 financial resources to keep our facility always in  
6 compliance and staff for the Quality and Risk  
7 Departments.

8 I'd like to introduce to you Dr. Carl  
9 Sherter.

10 DR. SHERTER: I'm old, also, but that's  
11 okay. I adopt my pre-filed testimony.

12 My name is Carl Sherter. I'm the recent  
13 Chief of Staff of Waterbury Hospital. I'm a member of  
14 the hospital's Board of Trustees and on its Finance  
15 Committee.

16 I'm an original member of the task force  
17 that examined the hospital's opportunities with various  
18 capital partners.

19 I'm a practicing pulmonary and critical  
20 care physician. I'm in private practice, attending  
21 physician at both Waterbury and St. Mary's Hospitals.

22 I'm Chairman, proud Chairman of the State  
23 of Connecticut's Medicaid Pharmacy and Therapeutics  
24 Committee.

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1 I've served as a volunteer since the  
2 inception of this committee. I helped write its bylaws.  
3 I've Chaired every meeting for over 13 years.

4 We have saved the State of Connecticut  
5 tens of millions of dollars and provided the most liberal  
6 list of medications for Medicaid patients. I understand  
7 delivery of affordable health care to the underinsured.  
8 These are our most vulnerable patients.

9 Over the last four years, we've looked for  
10 capital partners. We've heard health care has changed,  
11 and we've changed our goals.

12 Under the Affordable Care Act, health care  
13 systems will attempt to keep patients healthy and prevent  
14 hospitalizations. This will require a robust system of  
15 care, data driven, with ancillary services that provide  
16 the best care available to every patient.

17 Every health care system is starting to  
18 build this model. Our chosen partner, Prospect Health,  
19 has a system in place as proof of success with the system  
20 in multiple states. It will be up and running in months,  
21 not years.

22 Part of my due diligence was to visit a  
23 two-hospital system in Rhode Island that Prospect  
24 acquired about a year ago. We met with their Board



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1 President, their CEO, their Chief Nursing Officer and six  
2 physicians, who proctor the system. One physician was in  
3 private practice, the others voluntarily employed.

4 We got to spend nearly two hours with this  
5 group and asked numerous questions. They said the best  
6 way to sum up the experience was that Prospect was real  
7 and delivered all that they promised, and physicians were  
8 very happy.

9 They were practicing accountable care  
10 medicine within months and it's working. The patients  
11 are happy and get much better care than the old way of  
12 practicing medicine. In Rhode Island, Prospect is  
13 eagerly taking on a Medicaid population.

14 Hundreds of physicians have signed up over  
15 the first year. They like the new model Prospect has  
16 offered.

17 This venture will be good for the proud  
18 city of Waterbury. Our population is older than most  
19 other Connecticut cities. The poverty rate is over 20  
20 percent. Our unemployment is over 12 percent.

21 This venture will help stabilize our city  
22 and help our city move into the next phase of its  
23 existence. Possibly, a city of health care and higher  
24 education. I haven't passed that by the Mayor yet, so

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1 you should know that.

2 Waterbury has provided excellent health  
3 care to the community. I'm proud of the over 1,000  
4 physicians we've trained, many still in our area.

5 We have medical students from all three  
6 Connecticut medical schools. I'm proud of the nurses,  
7 certified aides, respiratory therapists, physicians'  
8 assistants and pharmacists that we've trained.

9 I'm proud of the staff of the hospital  
10 earning numerous awards, quality health care, in spite of  
11 the hospital's financial constraints.

12 As I've stated, for the last four years,  
13 I've represented the medical staff at Waterbury Hospital  
14 and the patients that this hospital serves in its attempt  
15 to find a capital partner.

16 I was at every meeting. Prospect has met  
17 numerous times with the physicians who practice in  
18 Waterbury. They have a full-time physician liaison, John  
19 Holiver, who is there, who is always available, has  
20 reached out to every physician group.

21 He comes to the staff executive committee  
22 meeting monthly to report on progress and answers  
23 questions. This makes the process completely  
24 transparent.

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1           The physicians have asked every question  
2 and gotten honest answers. They support this venture.  
3 Over 300 Waterbury physicians have already signed up for  
4 Prospect's Accountable Care organization. This  
5 demonstrates their support.

6           After almost 40 years of practice in  
7 Waterbury Hospital, I've seen its recent problems as a  
8 standalone hospital. With an average physician age of  
9 over 59 years, it's getting increasingly difficult to  
10 bring young health care workers to Waterbury.

11           They want a secure future in their  
12 practice. They want modern equipment to diagnose and  
13 treat their patients. They want a stable future with a  
14 capital partner, who will help with this economy of  
15 scale.

16           They know the health care delivery model  
17 has changed. They want to hit the field running with  
18 this proven system. Prospect offers this.

19           The people of Waterbury want excellent  
20 health care in their own city. They are a community of  
21 family values, who support one another.

22           Most of my patients come to the office  
23 with family members. They ask me is it going to happen?  
24 I answer we certainly all hope so.

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1 We need a capital partner to make this  
2 happen, and Prospect is an excellent choice. Thank you.

3 DR. LEW: Mitchell Lew, President of  
4 Prospect Medical Holdings.

5 Greater Waterbury Health Network and  
6 Prospect, committed to this community. Who is Prospect?  
7 We are a health care services company, and we operate  
8 local community hospitals, and what is standard within  
9 our company is that we utilize local governance and local  
10 physician leadership.

11 We make investments in our hospitals and  
12 our communities. For example, recently in Rhode Island,  
13 we've made significant investments into the facility.  
14 We're beautifying the entrance, we're expanding the  
15 emergency room, and we've built out the GI lab, and, in  
16 two communities in Southern California, we have opened  
17 two new hospitals, one in Orange County and one in  
18 Bellflower.

19 The stability that we provide is continued  
20 employment and creation of new jobs, and we also expand  
21 programs and services to improve access and quality.

22 We opened an emergency room in our  
23 hospital in San Antonio, Texas, and we have opened  
24 several urgent cares in Providence, Rhode Island and,

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1 similarly, in California. We have opened several urgent  
2 care and wellness clinics.

3 A little bit about the hospitals that we  
4 operate. Fourteen community hospitals, seven in  
5 California, four in Texas for about four years, two in  
6 Rhode Island, and it's been almost two years, and one  
7 recently we opened in New Jersey.

8 We serve many different communities. Many  
9 of the hospitals that we have are in underserved  
10 communities. To us, we take all types of health  
11 insurance, because, to Prospect, a patient is a patient.

12 All of our hospitals across our system  
13 provide various services. As you can see, medical,  
14 surgical, psychiatric, so we've got a lot of experience  
15 in multiple areas, but we also have many outpatient  
16 clinics and centers, because, in our model, not all care  
17 is delivered in a hospital.

18 And while we are a hospital company, we  
19 also are a medical group company. We operate and manage  
20 many physician groups, and you can think of our physician  
21 entity as a multi-specialty health care provider without  
22 walls, and, so, we link our physicians in what we call  
23 Independent Practice Associations, or IPAs, where  
24 physicians focus on delivering the best care.

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1 In this model, physicians can be employed  
2 or they can be independent. We are an open model, and,  
3 so, whatever a physician desires, to be employed or  
4 remain independent, we can accommodate them.

5 We're a very large group in Southern  
6 California. We've been operating for over 20 years.  
7 And, also, growing in Texas, where we have nearly 500  
8 doctors. Rhode Island, it's 300 doctors, and New Jersey  
9 about 125 physicians.

10 We contract with all health plans. We  
11 have nearly 9,000 physicians under contract, taking care  
12 of over 300,000 patients, and we coordinate care across  
13 the entire continuum, and what that means is, if a  
14 patient is in a hospital, or in a skilled nursing  
15 facility, or at home, we follow the patient throughout  
16 their care.

17 Our goal is to achieve the best clinical  
18 outcomes and the best patient experience, because we want  
19 our patients to go and tell their family and friends to  
20 come get their care with Greater Waterbury and Prospect.

21 Now through our experience of owning and  
22 operating hospitals and medical groups, we've come up  
23 with what we feel is a very unique model of care, which  
24 we call Coordinated Regional Care, or CRC, and what

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1 Coordinated Regional Care does is it integrates the  
2 hospitals and the physicians and other medical and  
3 community providers, so, in this community, there might  
4 be a durable medical equipment company, or a palliative  
5 care company, or a skilled nursing facility.

6 We work with the local providers, and we  
7 also will work with the local health plans to coordinate  
8 the care, because we need to do that to improve care and  
9 get that patient satisfaction, and this model we have  
10 already implemented in several different regions in  
11 California, Texas and Rhode Island, and, as I alluded to  
12 earlier, currently underway in New Jersey and already  
13 here in Connecticut.

14 Population health management, you hear  
15 this term frequently, and basically to us what that means  
16 is that the care of every member in this community  
17 matters.

18 Our unique model of care will provide  
19 higher value, and what that means is that great care does  
20 not need to cost more.

21 Improving care and outcomes, so how  
22 exactly do we do this? What is the secret to providing  
23 for better care? And, so, we take a patient-centered,  
24 but a physician-led approach. We have multi-specialty

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1 care teams that identify the highest risk patients, and  
2 those are usually the sickest five percent, and these  
3 teams are comprised of nurse practitioners, pharmacists,  
4 social workers and health educators that work together,  
5 and they will actually be available 24/7 to these  
6 patients, so if a patient needs to call, they call us,  
7 and, if necessary, we will go to their home to evaluate  
8 whether or not they need to be hospitalized. That's the  
9 type of care that we provide. We engage the patient and  
10 the family. We have this homebound program that I just  
11 spoke of.

12 Disease-specific care plan, so specific  
13 for diseases, such as diabetes, or congestive heart  
14 failure. We have certain protocols that we follow to  
15 make sure that a patient has the best standard of care  
16 that is evidence-based.

17 We also are integrating behavioral health.  
18 As we know, behavioral health is a very common problem in  
19 all communities, and it's important, when you're taking  
20 care of one's physical health, also to integrate taking  
21 care of their behavioral health needs.

22 We have quality care coordinators that  
23 reach out to patients every day to call them and remind  
24 them that they need to come in to their physician for



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1 their testing, whether it be a mammogram, or to check  
2 their cholesterol. We have teams of coordinators that do  
3 this.

4 And then following patients, as I  
5 mentioned earlier, whether it's a hospital, a skilled  
6 nursing facility, or some other institution, we case  
7 manage and we follow across the entire continuum, and  
8 it's a physician-led network.

9 MR. ALEMAN: Hi. I'm Steve Aleman, Chief  
10 Financial Officer, Prospect Medical Holdings, and I  
11 wanted to take just a few moments to walk through the  
12 demonstrated kind of financial history of Prospect  
13 Medical Holdings and the demonstrated financial  
14 performance.

15 What's here on the slide, I reference both  
16 the growth and revenue. This is the compound annual  
17 growth rate and revenue and adjusted EBITDA since 2011.  
18 2011 is important from a date, because this is the year  
19 before we started acquiring facilities outside of  
20 California.

21 If I included the growth rate prior to  
22 that, when the company really came together, the medical  
23 group and hospital segment back in 2007, the growth rates  
24 would even be higher, but this would give kind of a fair

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1 review over the last four years.

2 On the revenue compound annual growth  
3 rate, that was really driven between organic growth, and  
4 that's growth in our existing facilities prior to  
5 acquisition, as well as strategic growth, and those are  
6 acquisitions, and that strategic growth was really  
7 focused to date in these numbers on the Rhode Island  
8 transaction, CharterCARE Health Partners, as well as the  
9 Nix Health System in San Antonio, Texas.

10 Conversely, though, the adjusted EBITDA  
11 growth rate of 25.6 percent is really almost solely  
12 driven by organic growth rate, and that organic growth  
13 rate is driven by continued process improvements in our  
14 facilities, continued cost deficiencies, movement towards  
15 managed care and related supplemental payments that have  
16 driven both the top line revenue growth, as well as  
17 adjusted EBITDA.

18 Focusing on acquisitions and integration,  
19 I've touched upon CharterCARE Health Partners. I'd also  
20 like to highlight a recent transaction of ours in New  
21 Jersey, East Orange General Hospital, because they both  
22 have similar traits that, when we stepped in and signed  
23 the APA for those particular transactions, they both had  
24 a negative run rate, of which we invested into those

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1 facilities, just like we're investing from a manpower  
2 standpoint in Greater Waterbury Hospital to help begin to  
3 turn performance around and work directly with  
4 management.

5 And, indeed, we were able to turn the  
6 monthly run rate financial performance of both those  
7 facilities around from where they were running at about a  
8 negative \$1.2 million a month to break even or positive.

9 The East Orange General Hospital facility,  
10 we entered into that transaction in 2014. It was a  
11 fairly lengthy regulatory review process, but we just  
12 closed that in March, and the first month of financial  
13 performance under us they actually were accretive month  
14 one and actually had a positive EBITDA month one for the  
15 month of March, and that really gets to this last point,  
16 that we work with the given facilities to help improve  
17 performance, operational and financial, and anticipate  
18 the acquisitions will be accretive year one, due to that  
19 improved performance.

20 How do we do it, and how do we deal? I  
21 specifically deal with the rating agencies. The focus  
22 has been our diversified model, and our diversified model  
23 is fairly unique, in that we reduce our concentration or  
24 our risk not only away from a given business segment,

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1 such as whether it be a hospital segment or medical group  
2 segment, but as well as various states, payers and  
3 streams of revenue.

4 The medical group side, and this  
5 diversification also helps give us steady and predictable  
6 cash flow to help ultimately reinvest into our  
7 facilities, that diversification comes on the medical  
8 group side, with the steady capitation payments and  
9 management fees, on the hospital side, with the  
10 diversified payer mix between commercial, Medicare,  
11 Medicaid, as well as managed care and supplemental  
12 payments that are driven from those programs, and it  
13 gives us the ability to satisfy our acquisition  
14 commitments, without taking on additional debt.

15 Specifically, going back to the  
16 acquisitions I've highlighted, the Nix in San Antonio and  
17 CharterCARE in Rhode Island, we acquired those solely off  
18 cash generated from operations and the capital  
19 commitments that we have carried forward, those formal  
20 commitments in Rhode Island, and the significant dollars  
21 we've invested into the Nix have all been from cash flow  
22 generated from operations, without taking on additional  
23 debt.

24 Which gets to what is our access to

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1 capital, and I've highlighted what we have the ability to  
2 do is not only leverage the strength of our financial  
3 performance, the cash generation to reinvest that into  
4 our facilities, but we also have taken a very  
5 conservative approach to taking on debt, solely for the  
6 reason that, if from a strategic purpose there becomes a  
7 need or desire for us to go out and tap capital markets,  
8 that we have the ability to do that.

9 Our industry leverage ratio comparison  
10 gives our current industry comparison to other key, other  
11 public for-profit companies, and our goal is generally to  
12 keep our leverage ratio below four.

13 You can see we're well below that, which  
14 gives us the ability at any time to access the markets,  
15 both bank and bonds. In addition to that, we were a  
16 publicly-traded company and have maintained that  
17 reporting discipline, as well as financial discipline,  
18 which makes us attractive to private equity groups and  
19 the strength, the financial strength that they can  
20 provide.

21 We actually are with Leonard Green &  
22 Partners, who provide us that capital backstop, should we  
23 ever need it. Today, we have never needed to access them  
24 as a financial backstop or seek any additional

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1 investments, and that's kind of the various access to  
2 capital and kind of the strength that our model provides.

3 MR. CROCKETT: Von Crockett, Senior Vice  
4 President for Corporate Development for Prospect.

5 As Mitchell Lew, Dr. Lew, indicated, our  
6 physician groups have an extensive program for managing  
7 the health of the members that they serve, and, in the  
8 process of measuring the health, one of the national  
9 groups, which is called CAPG, that measures the  
10 effectiveness of physician group performance, has awarded  
11 our physician groups in California the status of -- Elite  
12 status, which is in the top four to five percent of  
13 medical groups, as it relates to providing appropriate  
14 and efficient and effective care for our patients, and  
15 we're very proud of that.

16 Additionally, our medical groups have also  
17 been recognized and rewarded by the Medicare program, and  
18 we have received -- all of our medical groups have  
19 received either a four or a five star for Medicare, as  
20 well as being recognized by the Department of Managed  
21 Health Care and cardiovascular, as well as cholesterol  
22 and diabetes care.

23 On the hospital side, recently within  
24 Rhode Island, our Cancer Center has recently been

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1 designated by the American College of Surgeons as an  
2 academic comprehensive Cancer Center, and it's one of  
3 only 15 percent within the entire nation.

4 Additionally, within Rhode Island, Blue  
5 Cross has recognized our facilities for their surgical  
6 care in hip, knee and spine, as well as the surgery  
7 programs.

8 In Texas, we've recently received a Center  
9 of Excellence from Joint Commission for Bariatrics, and,  
10 in California, our hospitals have received top 10 percent  
11 nationwide, as it relates to provision of care within  
12 surgery.

13 However, there have been a few recent  
14 events within California that have recently come to light  
15 that have caused us to enhance our quality and expand our  
16 oversight of quality to our various California, as well  
17 as the proposed acquisitions.

18 With me we've brought Debbie Berry, who  
19 has recently been hired as the Chief Quality Officer and  
20 has an extensive background in quality and working in a  
21 large health care organization that has had oversight  
22 over multiple facilities, and she'll be testifying here  
23 shortly, in terms of what our enhanced quality program is  
24 going to be.

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1 To touch briefly upon the events that have  
2 occurred within California, I'll just spend a few minutes  
3 on that for the room.

4 We, in California, we have recently now  
5 seven hospitals, but, at the time, we had six hospitals,  
6 and they're consolidated under two licenses, and, so,  
7 within the six-hospital structure, we had two of the  
8 hospitals that recently received notification from CMS  
9 that we were in violations of their conditions, Medicare  
10 conditions of participation.

11 The first issue was within Los Angeles  
12 Community Hospital, which is a three-campus system in  
13 East Los Angeles, and the issue arose. The hospital did  
14 a self-report to CMS, as it related to an allegation of  
15 physician misconduct.

16 The hospital had taken appropriate actions  
17 at that time, and when the Department of Health came out  
18 to do a survey, they had found that the actions that the  
19 hospital had put into place had not been adhered to by  
20 the physician and were not strong enough.

21 As a result of that issue, what's called  
22 an immediate jeopardy violation, as it relates to not  
23 safeguarding patient rights, and that occurred in  
24 November of 2015. The immediate jeopardy violation was



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1 abated during the time of the survey, however, as part of  
2 the survey process, the organization was found to be in  
3 violation of five Medicare conditions of participation,  
4 which include the physician rights, nursing services, and  
5 infection control, among part of those.

6 As part of receiving the immediate  
7 jeopardy violation, CMS also placed the hospital on a 90-  
8 day proposed termination track of the Medicare agreement,  
9 giving the organization an opportunity to submit a plan  
10 of correction to correct the deficiencies.

11 The organization submitted the plan of  
12 correction, and a resurvey of the hospital occurred in  
13 February of 2016.

14 During the resurvey process, the issue  
15 associated with the immediate jeopardy was found to be we  
16 were in compliance associated with that, however, there  
17 were two issues, where the facility remained out of  
18 compliance, and it was infection control and nursing  
19 services.

20 At that point, CMS extended the proposed  
21 termination track to June 21st and gave the organization  
22 an opportunity to submit a plan of correction.

23 The plan of correction was submitted in  
24 early April, and the organization just recently underwent

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1 the second resurvey by the Department of Health on the  
2 week of April 25th. The resurvey resulted in all  
3 deficiencies being cleared, and, as such, we expect to  
4 receive shortly a report from CMS, clearing the  
5 organization of all deficiencies, as well as removing the  
6 termination track associated with -- before the June 21st  
7 deadline.

8 The second issue occurred at our campus,  
9 which is called Southern California Hospital. It's a  
10 three-campus system underneath one license, with the  
11 focus of the survey issues primarily at the one campus,  
12 which is Culver City.

13 A little backdrop, which is in early of  
14 January of 2015, the organization was in the process of  
15 doing construction work, and our contractor had a small  
16 localized fire on the roof that caused for the damage of  
17 the HVAC system, making it inoperable.

18 The organization put temporary measures in  
19 place in the summer of 2015, and those measures were  
20 inadequate. As a result of that, there were complaints  
21 that were issued to CMS regarding primarily temperature  
22 and humidity within the organization.

23 During the survey process, during the  
24 survey process, the organization was issued an immediate

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1 jeopardy for being out of compliance for temperature and  
2 humidity in the organization, which was abated during the  
3 survey process.

4                   During the survey process, at that point,  
5 we received notification that the organization was also  
6 out multiple areas of Medicare conditions of  
7 participation.

8                   While the hospital was in the process of  
9 responding to that report, CMS conducted what's  
10 considered to be a full validation survey, and that  
11 survey occurred on December the 18th, the week of  
12 December the 18th, and the results from that survey is  
13 that Medicare found that the organization was out six  
14 conditions of participation, which included infection  
15 control, and issued the organization a second immediate  
16 jeopardy, specifically to the sterilization of surgical  
17 instruments in the operating room suite.

18                   That second immediate jeopardy violation  
19 was abated during the survey process, and surgeries  
20 resumed at that time.

21                   As part of the issue of being issued the  
22 immediate jeopardy violation, the license, which included  
23 the three hospitals under Southern California Hospital,  
24 was issued a proposed 90-day termination of the Medicare

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1 provider agreement at that time.

2 The organization was given the opportunity  
3 to submit a plan of correction, and that plan of  
4 correction was submitted on March 22nd.

5 The resurvey by the CMS or Department of  
6 Health was conducted on the week of April the 4th, and we  
7 are still currently awaiting the results of that CMS  
8 survey.

9 One of the things that, as part of  
10 receiving these issues that I've outlined, a couple of  
11 points. The first one was that, under both of those  
12 scenarios, there was actually no allegation that actual  
13 patient harm occurred underneath any of the violations or  
14 the immediate jeopardy citations that were given.

15 However, the organization takes these  
16 concerns extremely serious, and we started working on  
17 them immediately upon being informed by the Department of  
18 Health, as well as CMS.

19 As part of our response to make sure that  
20 the organizations were going to be meeting the conditions  
21 of participation, we hired a national consulting group to  
22 come in and assist both organizations until they're  
23 actually cleared, and they currently are still working  
24 with us, as related to the Southern California Hospital.

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1                   With that, we have modified multiple of  
2                   our operating policies, as well as enhanced our quality  
3                   program and oversight.

4                   MR. ZINN ROWTHORN: So this is probably a  
5                   good juncture to remind folks that this is our third  
6                   hearing with Prospect Medical Holdings. We had two  
7                   hearings in connection with the ECHN transaction, and we  
8                   had very substantial discussion about these immediate  
9                   jeopardy issues.

10                  We are taking, in this proceeding, notice  
11                  of the record of that proceeding, so all of the material  
12                  and testimony at that proceeding is part of this record  
13                  and vice versa.

14                  It's very helpful for those, who are here,  
15                  however, to have an overview of this topic, in  
16                  particular, and, in particular, to have updates, but I do  
17                  want to remind folks that the extensive discussion  
18                  already on this subject is part of this proceeding, as  
19                  well.

20                  Also, I see that there are some folks  
21                  standing. There are some seats up here, if people would  
22                  be more comfortable sitting down.

23                  I'm reminded that the transcripts from the  
24                  two days of testimony of the ECHN proceeding are already

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1 available online and on our website, if folks are  
2 interested in looking at those. I apologize for that  
3 interruption. Please proceed.

4 MS. BERRY: Hi. My name is Debbie Berry.  
5 I'm the brand new Chief Quality Officer for Prospect  
6 Holdings, Medical Holdings, and I'm going to speak to you  
7 a little bit about our future and our plans to improve  
8 quality and patient safety across the company.

9 First of all, our philosophy is that the  
10 right care is provided to the right -- the right patient  
11 receives the right care at the right time in the right  
12 setting, and our mission is to improve our care outcomes,  
13 provide patient safety, integrity, communication and  
14 collaboration with all our colleagues.

15 Our goal is to become a high reliability  
16 organization, to promote patient focus, high quality,  
17 safe, compassionate, efficient and effective care.

18 Being new to the company, I had to start  
19 somewhere, so I adopted, we agreed to adopt the quality  
20 of care framework, which says you need to have that  
21 infrastructure in place, you build the processes to  
22 support that infrastructure, and then you measure, you  
23 have outcomes, and you measure those outcomes and  
24 continue on from there, so that's kind of where I'm

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1 starting.

2 First of all, I was asked to put together  
3 a draft quality and patient safety structure for the  
4 company, remembering that I've only been here for two  
5 weeks. I used my experience from a very large health  
6 care system, 173 hospitals, and, also, a much smaller  
7 health care system that consists of seven hospitals.

8 I pulled some of the best practices from  
9 both of those, plus did as much research as I could in  
10 evidence-based journals, in quality improvement journals,  
11 and, also, took a very close look at what was happening  
12 across the company.

13 So, based on this, this is the structure  
14 that I have put together, and, again, it may change a  
15 little bit. I've only been here two weeks.

16 MR. ZINN ROWTHORN: Can I interrupt before  
17 you do that?

18 MS. BERRY: Yes.

19 MR. ZINN ROWTHORN: It perhaps would be  
20 helpful if you told us a little bit about your  
21 background.

22 MS. BERRY: Oh, sure. Absolutely.

23 MR. ZINN ROWTHORN: Thank you.

24 MS. BERRY: I'm sorry. I'm a nurse and

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1 always a nurse. A nurse first and always. I have been a  
2 nurse for 31 years. I have been in clinical practice  
3 much of my career, either as a clinical nurse, as an  
4 educator, or as a clinical specialist, so I'm very in  
5 tune to the clinical world.

6 I have experience in performance  
7 improvement, both in hospitals and across the system,  
8 and, most recently, I spent the last seven years with the  
9 Hospital Corporation of America, HCA, where I was first  
10 an Assistant Vice President of Quality and Clinical  
11 Operations, and then a Vice President of Quality and  
12 Patient Safety for the HCA system in one of their  
13 divisions.

14 In one division, I had oversight of 17  
15 hospitals, plus multiple surgery centers, freestanding  
16 EDs, etcetera, and, in the other system, in the Gulf  
17 Coast system of Houston, I had oversight for 14  
18 hospitals, along with surgical centers and on site, free  
19 site EDs.

20 I have taught for many years part-time in  
21 nursing programs, Baccalaureate and regular, and, just to  
22 give you some of my credentials, I am published, I am  
23 subject matter expert on quality and patient safety for  
24 Lippincott, for Core Measure events.



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1 I produce in their policy and procedure  
2 manual, and I'm also a subject matter expert for two  
3 universities on quality and patient safety. Anything  
4 else?

5 MR. ZINN ROWTHORN: Thank you.

6 MS. BERRY: Okay, good. Thank you. Let  
7 me talk a little bit about our proposal here. Again, we  
8 have a Chief Quality Officer.

9 The important thing is that we have  
10 decided that we are -- we have grown, so we're going to  
11 divide into an eastern regional and a western regional VP  
12 of Quality to help support and provide facilitation to  
13 the facilities on the east coast, Texas and on, or the  
14 east coast and then the west coast and Texas.

15 Beyond that, one thing that I found it  
16 very clear to me and, also, based on past experiences, we  
17 really needed to get in front of the survey activity and  
18 build our own internal consulting firm, I guess, around  
19 survey readiness, so we put together a proposal that we  
20 have a VP of Regulation and Accreditation programs, and,  
21 under that, we are going to build a system of experts  
22 that can come out before a survey happens, come out if a  
23 survey happens where we have an issue, and, also, help  
24 build tools and build expertise across the company around

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1 those high-risk areas, such as infection prevention,  
2 environment of care, life safety clinical practice, so  
3 we're going to have our own preemptive program, so that  
4 we can really monitor how well we are towards survey  
5 readiness.

6 And, again, all surveys do, all  
7 accreditation does is make sure that we're doing the  
8 right thing for the patient, so it's going to be a very  
9 patient-focused program.

10 I'm going to switch to the next slide.  
11 Part of what I was asked to speak to is a model that I  
12 have. I do like to have a corporate Quality and Patient  
13 Safety Steering Committee that has input from the  
14 hospitals in the company, and, also, not just the  
15 hospitals, but certain -- it's a multidisciplinary team,  
16 so there will be physicians, nurses, that kind of thing,  
17 so it's kind of a Steering Committee.

18 I'm just going to show the structure  
19 there, and I'll talk a little bit later of some of the  
20 roles, but it will flow from corporate, and then there's  
21 some regional activity, and then the hospitals will  
22 actually roll up into those regional activities.

23 The main purpose of that is communication.  
24 We need to maintain communication across the entire

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1 company, so we can learn from each other, so we can share  
2 best practices, as my colleague over there had mentioned,  
3 and mutually move forward into the 21st Century.

4 The other thing that I have a slide here  
5 is just to show -- am I stuck? Oh, there we go. I'm  
6 sorry. The other thing within the Steering Committee, we  
7 will also be building some subcommittees, the  
8 subcommittees around things, such as clinical excellence,  
9 and when I mentioned those, I mentioned things like  
10 sepsis and all those very high-alert, very serious  
11 illnesses, infectious disease preparedness, so that, if  
12 something happens around infectious disease, we are ready  
13 to get out the facilities and help.

14 Certainly, quality and patient safety,  
15 medication safety, hospital-acquired infections and  
16 hospital-acquired conditions. These committees may not  
17 all start. There will be probably a gradual progression,  
18 but really try to get the input and get a focused  
19 movement across the company.

20 Under these committees, we may have work  
21 teams, and, in work teams, I try to pull people closest  
22 to the work to help us design best practices, based on  
23 best evidence, and share across the company.

24 I heard a lot about high reliability

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1 organizations, that both Rhode Island is very involved in  
2 and, also, East Connecticut. I am also -- I'm sorry.  
3 The Connecticut hospitals.

4 I am also a very big believer in high  
5 reliability. It's the only way that we can decrease  
6 medical error in a hospital system.

7 We are going to move forward into that  
8 high reliability program. We are adopting high  
9 reliability behaviors to ensure a reduction in overall  
10 medical errors.

11 We are working on leadership commitment,  
12 and lot of work has already been done at the CEO level  
13 and CNO level just in the short period of time we've been  
14 here.

15 We are going to be working on building a  
16 very strong culture of safety and widespread deployment  
17 of highly effective performance improvement tools. Many  
18 of those tools are high reliability tools, such as SBAR,  
19 which is a communication tool that we use in nursing and  
20 health care, in general.

21 Part of our strategies to make, our  
22 outcomes that we're looking for, we are going to support  
23 ongoing survey readiness, and I mentioned the team that  
24 we're going to have in place.

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1                   We are going adopt patient experience,  
2                   clinical excellence and high-reliability best practices,  
3                   create and adopt data dashboards and analysis tools, so  
4                   that we can benchmark not only with our company, but,  
5                   also, with those, who provide the best care in the  
6                   nation, so we're going to benchmark against the top 10  
7                   percent of the country.

8                   We're going to promote consistent risk  
9                   identification and medication, so what we learn from some  
10                  facilities on the east we can share with facilities on  
11                  the west and vice versa.

12                  We're going to optimize pay for  
13                  performance and publicly reported outcomes. Any time  
14                  that the state and federal government wants to pay me for  
15                  doing the right thing, I am 100 percent behind that, so  
16                  we are going to work through that.

17                  And, also, something very important is  
18                  integrate technology. Technology is growing so very  
19                  quickly we want to move forward with it and make sure  
20                  it's integrated in our quality and patient safety plan.

21                  Also, I had mentioned the quality and  
22                  patient safety councils that we're envisioning. The  
23                  purpose of those quality and safety councils will be to  
24                  analyze data and trends for performance improvement

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1 opportunities, assist with development of our quality and  
2 patient safety agenda, which we hope to update every  
3 year, provide organizational knowledge and systems  
4 thinking, motivate and strategize for organizational  
5 change, and ensure compliance with action items, so that  
6 we don't have a repeat of what we had on the west coast.

7 As part of that team that we are putting  
8 together and as part of this council, there will be  
9 monitoring of action plans, and, also, provide oversight  
10 for charter committees and work groups.

11 MR. ZINN ROWTHORN: So let me -- were you  
12 just about to hand --

13 MS. BERRY: I was going to hand off.

14 MR. ZINN ROWTHORN: Let me, if you don't  
15 mind, ask you a couple of questions at this juncture.

16 MS. BERRY: Absolutely.

17 MR. ZINN ROWTHORN: And I recognize that  
18 you're new to the organization, but it sounds like you've  
19 had the chance to roll up your sleeves and propose a  
20 detailed plan with respect to quality improvement and  
21 maintenance.

22 Have you had the opportunity to understand  
23 in some detail the problems that arose in the California  
24 hospitals?

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1 MS. BERRY: I have. I have reviewed all  
2 the action items, all the standard violations or  
3 conditional violations, whatever, and the action items  
4 for those.

5 I actually have read them all. I believe  
6 that they've done a thorough, incredible job with  
7 identifying those issues and going after them. I think  
8 they've really gone after them well from my experience.

9 MR. ZINN ROWTHORN: Okay and can you talk,  
10 if you could, about whether and how the steps and  
11 structural changes that you've outlined would have  
12 prevented those issues from occurring?

13 MS. BERRY: Sure. Well, number one, I  
14 think that the most important part to prevent is to have  
15 the survey readiness team available with a group of  
16 experts on those high-risk areas, so that we will  
17 actually go in and do pre-surveys before anybody comes  
18 in.

19 I plan on scheduling them at least yearly  
20 at this point, so that a group will come in of experts  
21 and do essentially a mock survey.

22 Not only will they say this is wrong, this  
23 is wrong, this is wrong, they're going to also share  
24 those tools, share the support, share the expertise, so

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1 that they improve immediately, and then continue to  
2 monitor that action plan, and that's key.

3           You can't just go in and say what's wrong.  
4 Part of this team's function will be to monitor  
5 everything that we found, monitoring it to completion,  
6 and then making sure they continue to monitor it, whether  
7 it's a sample or whatever, to make sure that they are  
8 achieving compliance with the standards, so that is --  
9 it's a model that has been used across many  
10 organizations, and I think it's going to work very well  
11 for us, and actually kind of even being a little  
12 proactive now. Some of our other facilities are trying  
13 to get some specialists in to continue to be survey  
14 readiness, so I think that will help.

15           MR. ZINN ROWTHORN: Have you had the  
16 opportunity to gain an understanding of Waterbury  
17 Hospital's quality performance?

18           MS. BERRY: I have. I'm certainly not an  
19 expert. I did spend all day yesterday at Waterbury. I  
20 had the great pleasure meeting with Joey and Susan. They  
21 have a very robust program.

22           We shared a few best practices across the  
23 table, but I am very impressed with their program. I  
24 intend to use them, some of their practices, as best



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1 practices, because I have identified them as best  
2 practices, so that we can share across the company, and I  
3 think they also have some opportunities, and we're going  
4 to continue to work on those opportunities, as well. I  
5 think it will be a very good partnership.

6 MR. ZINN ROWTHORN: One of the things that  
7 we've struggled to do since becoming aware of the  
8 immediate jeopardy issues is to understand those issues  
9 in context.

10 Just the phrase, immediate jeopardy, has a  
11 severe ring to it, and understand that the hospital could  
12 be at risk of no longer being able to participate in the  
13 Medicare or Medicare program. Particularly, a number of  
14 hospitals grouped under two licenses is alarming.

15 It's something with respect to these  
16 systems that we're looking at here. In Connecticut, it's  
17 something that I don't believe there's much, if any,  
18 experience with, threats of immediate jeopardy  
19 terminations.

20 How many hospitals are part of the HCA  
21 system?

22 MS. BERRY: One hundred and seventy-three.

23 MR. ZINN ROWTHORN: One hundred and  
24 seventy-three. Do you have experience in those hospitals

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1 with immediate jeopardy termination threats?

2 MS. BERRY: I'm not going to speak  
3 directly to HCA, but I can tell you that, in the past 10  
4 years, I have experienced seven immediate jeopardies with  
5 conditions, conditional status, and had to work with the  
6 sites to get them out of that, so it's not -- I mean and  
7 especially certain areas of the country seem to be more  
8 attractive than others, and Florida is one of those areas  
9 that there's a lot of activity, a lot of state and CMS  
10 activity.

11 MR. ZINN ROWTHORN: What would explain  
12 regional differences in that?

13 MS. BERRY: How can I explain the  
14 regional?

15 MR. ZINN ROWTHORN: What would, for  
16 example? We've heard some reference to regional  
17 differences between, for example, California and here.  
18 Our understanding it's the same set of CMS regulations.

19 MS. BERRY: They are the same. I think  
20 it's more the activity of the state, how actively  
21 involved the state is in doing complaint surveys, or  
22 doing any kind of just random surveys.

23 In 2015, the state started doing surveys  
24 around infection control, discharge planning, and I think

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1 that increased -- that started in Florida very quickly.  
2 To my knowledge, it hasn't started over here in LA yet,  
3 so I think that's part of it.

4 MR. ZINN ROWTHORN: Okay and Mr. Crockett  
5 referenced the Department of Public Health, which I  
6 assume is a reference to the California Department of  
7 Public Health?

8 MR. CROCKETT: Correct.

9 MR. ZINN ROWTHORN: And, so, CMS is a  
10 federal regulator, federal program, so, for the benefit  
11 of those here, the relationship between a State  
12 Department of Public Health and CMS with respect to  
13 survey or immediate jeopardies issues is what?

14 MS. BERRY: Go ahead. Do you want to  
15 speak to that?

16 MR. CROCKETT: So the Department of  
17 Health, when a complaint is made to CMS, the Department  
18 of Health acts as an agent upon CMS and goes in and  
19 conducts the survey on CMS's behalf and will report the  
20 survey findings to CMS, at which point, then, CMS will  
21 make a decision or a determination upon those findings,  
22 so the Department of Health is an agent of CMS.

23 MR. ZINN ROWTHORN: Thank you for that.  
24 Just to paint this in broad strokes, I think what we

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1 would want to hear are some detailed explanations, I  
2 think you've touched on it, is to the extent we have an  
3 organization that has a good quality history, how can you  
4 assure us that that control of quality and maintenance of  
5 quality will be local, but within a national company will  
6 be supported by the national company?

7 MS. BERRY: Well, first of all, I'm a firm  
8 proponent if it's not broken, I'm not going to fix it.  
9 I'm not going to spend the energy to fix it, so I think,  
10 right now, they have a lot of things that are not broken,  
11 so we will focus on things that may be.

12 According to CMS and Joint Commission, the  
13 onus or responsibility for oversight of the quality  
14 patient safety program falls to that Board, the local  
15 Board.

16 We serve or we will serve as facilitators,  
17 as support sharing best practices. We are I like to say  
18 very much kind of a facilitation and, at some point,  
19 consulted, however, if there are issues that are, for  
20 lack of a better term, may place a patient in immediate  
21 jeopardy of harm, or if there are issues that are new  
22 regulatory, you know, CMS changes, conditions,  
23 participation frequently, the Joint Commission changes  
24 things, then we will reach out to them and say, you know,

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1 we need to work on this, because it's a new regulation.

2 So, again, I don't see us forcing things  
3 down. Number one, it's just not my style, but very much  
4 partnering with them.

5 MR. ZINN ROWTHORN: Thank you. I think  
6 this is a topic we'll probably hear more about today when  
7 we get to questions. I wanted to sort of identify some  
8 of the broad themes here in advance of our public  
9 comment. Feel free to continue with your opening  
10 comments.

11 MR. SPEES: Good afternoon, everyone. I'm  
12 Jon Spees, and I lead the transactions practice for  
13 Prospect. I wanted to spend just a little bit of time  
14 talking about the terms of the transaction and the  
15 commitments that we, Prospect, have made to both  
16 Waterbury Hospital and Greater Waterbury Health Network  
17 and, also, to the community as part of the transaction  
18 commitments, which have been described in our asset  
19 purchase agreement.

20 As Darlene mentioned, we're talking about  
21 essentially a \$100 million transaction, which is split  
22 \$45 million, in terms of the purchase price at closing,  
23 as well as a capital commitment of \$55 million.

24 The capital commitment is to be used for

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1 investment in GWHN's facilities in growth of its  
2 services, in development of the coordinated regional care  
3 model, and other investments in expanding assets and  
4 developing the system, and really finding ways to retain  
5 health care services in Waterbury, which are currently  
6 being exported to other areas, and retain jobs and build  
7 the community network here.

8 I wanted to just mention, so, Darlene  
9 talked about what a difficult year 2015 was for Greater  
10 Waterbury Health Network, and as the result and fallout  
11 from those difficult times, their cash reserves have been  
12 significantly depleted over the past year, to the point  
13 where there's some concern about whether or not there  
14 would be enough cash, as of the closing of the  
15 transaction, to satisfy the bond holders and allow them  
16 to transfer the assets to that, to Prospect.

17 So we've continued to monitor the cash  
18 position and forecasts of cash at closing, in order to --  
19 as Darlene also mentioned, you know, choosing a partner  
20 that was committed to close the transaction was key for  
21 them, and we've continued to work with them and actually  
22 have now agreed, based on the most recent estimate, to  
23 make a couple of changes in the transaction.

24 It doesn't reduce our overall commitment

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1 to the transaction. It just changes the allocation  
2 between purchase price and assumed liabilities and  
3 capital commitment, so, in order to increase the  
4 opportunity to actually close the transaction and satisfy  
5 the bond closers, we made a couple of fairly significant  
6 changes to the purchase agreement, the first being to  
7 eliminate the holdback, and there were provisions  
8 previously of a four-and-a-half-million-dollar holdback  
9 at closing that was to be used to satisfy any post-  
10 closing liabilities, and we've agreed to waive that  
11 holdback, which then frees up an additional four and a  
12 half million dollars of cash at closing.

13 And we've also agreed to limit the  
14 deduction from the purchase price for the liabilities  
15 that are assumed as of the closing, so that it can be --  
16 it will be limited in its amount, and we've agreed to  
17 assume liabilities in excess of that threshold amount up  
18 to an additional \$5 million.

19 That also will free up if there are  
20 liabilities at closing that are greater or free up cash  
21 at closing, and the trade there is, if we actually do end  
22 up assuming additional liabilities as the result of that,  
23 is that the offset would be against the future capital  
24 commitment, so, in total, the commitment is the same.

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1 It's just allocated slightly differently.

2 The last piece I'll mention on the capital  
3 commitment is that there's provision to restructure the  
4 capital commitment if there is a regulatory action that  
5 is discriminatory against for-profit hospitals, and the  
6 purchase agreement calls for that restructuring to occur  
7 in cooperation with the local Board.

8 We've had some conversation on this in the  
9 past, and, so, we're open to -- it's not our intention to  
10 ever eliminate the capital commitment dollars, and we're  
11 certainly also open to some limitations on the time  
12 period that we could defer any capital commitment  
13 expenditure in the unlikely event that that would occur.

14 MR. ZINN ROWTHORN: Thank you. And I  
15 should probably note, for the benefit of the folks, who  
16 weren't in our previous hearings, that we did have some  
17 discussion about that potential limitation on the capital  
18 commitment, and, in light of future regulatory or  
19 legislative acts, which would be perceived to be  
20 discriminatory at a for-profit hospital system, we've  
21 expressed some concerns about that, as you know, and, in  
22 particular, the concern that we are evaluating a deal, as  
23 structured now, its fairness and not with respect to  
24 potential unknowable future legislative action, so I'm



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1 glad to hear that you are thinking, in terms of some  
2 flexibility in that regard, and are sensitive to the  
3 concerns that we've raised about it.

4 MR. SPEES: Just, also, in addition to  
5 kind of the financial terms of the transaction, I wanted  
6 to talk about other aspects of our commitment and  
7 community benefits that will result from our commitments  
8 that we're making in connection with our purchase  
9 agreement.

10 Prospect has committed to continue the  
11 current charity care policies of Greater Waterbury Health  
12 Network, and we've also made a significant commitment to  
13 maintain the clinical services. There's a very long list  
14 of what's been defined as essential services in the  
15 purchase agreement that Prospect has committed to  
16 maintain.

17 As part of the transaction, we'll retain  
18 local management, and we'll create a local Advisory  
19 Board. I'll talk a little bit more about the local  
20 Advisory Board in a minute.

21 And we've also made our commitment to hire  
22 all of the employees of GWHN, who are in good standing,  
23 and I'll answer the question what does good standing  
24 mean?

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1           From Prospect's standpoint, we'll conduct  
2 a single screen on the employees as a pre-employment  
3 screen, and that relates to being -- not being on the  
4 exclusion list for participation in federal health care  
5 programs.

6           And we've also, in response to concerns  
7 about the quality issues in California, we've entered  
8 into a quality assurance letter, in which we commit to  
9 maintain and continue to work with the local Advisory  
10 Board with respect to Waterbury's quality programs, and  
11 we are very confident that that letter, which will govern  
12 in connection with the significant corporate resources  
13 and the program that Debbie spoke about, will give great  
14 comfort to people here in the community about maintaining  
15 and not just maintaining, but enhancing Waterbury's  
16 quality programs.

17           I'll talk a little bit about the Advisory  
18 Board. The Advisory Board is really a key part of  
19 Prospect's model. We very much believe that health care  
20 is delivered locally, and the Advisory Board is one of  
21 the key intersection points that we have with the  
22 community to consult with and to get information and  
23 feedback from community members, in terms of issues of  
24 importance to them, in terms of strategic plans for the

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1 health network, input into our capital plans, and  
2 essentially being our partner in developing the health  
3 network into what it can become.

4 They're also involved in medical staff  
5 credentialing and will be delegated responsibility for  
6 the medical staff credentialing, and they'll oversee and  
7 manage the accreditation process in concert, in  
8 cooperation with our corporate, our oversight plans.

9 As we talked about, they will be  
10 principally responsible for administering this quality  
11 assurance letter.

12 It's very key to us to have a close  
13 relationship with our local Board, in terms of how we  
14 conduct business going forward.

15 Our initial thoughts about the local Board  
16 is that it will be 11 members. Five will be from the  
17 current GWHN Board, and that will be nominated by their  
18 Governance Committee.

19 Prospect also believes very strongly in  
20 having physician input at the Board level, and, so, we  
21 want to have five physicians on the initial Board, as  
22 well as commitments made in the purchase agreement that  
23 the hospital's CEO will be part of the Board and, also,  
24 the chief of the medical staff, and recognizing the

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1 importance of the quality of the senior quality executive  
2 will also be on the local Board.

3 And it would be our plan to have staggered  
4 three-year terms for Board members, so that it would  
5 continue to evolve and reflect the current views of the  
6 community.

7 Selection criteria, obviously, we want our  
8 Board to represent the community, in terms of diversity,  
9 and to be qualified and possess backgrounds and  
10 experience that would be consistent with Board roles and  
11 responsibilities, and we want Board members, who are  
12 committed to GWHN's mission and to helping Prospect  
13 achieve that mission going forward.

14 MR. REARDON: Hi. I'm Tom Reardon,  
15 President of Prospect East. My first slide, you know,  
16 it's easy -- talk is cheap, and, so, we wanted to  
17 demonstrate what we do, rather than just what we say.

18 I should point out that Lester Schindel,  
19 the CEO of CharterCARE, is here today, and I think he'll  
20 comment in the public comment section, and with him is  
21 Kim Lumia, who many of you know, who had been the CEO at  
22 Sharon Hospital, working with Les at CharterCARE now, and  
23 will be working in New England with Prospect.

24 So, with respect to CharterCARE in Rhode

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1 Island, the two hospitals in Rhode Island, both Roger  
2 Williams Medical Center and Our Lady of Fatima Hospital,  
3 frankly were in a lot of trouble when we came in.

4 I must say that we're not all the way  
5 there, but we've turned them to a positive EBITDA. We  
6 formed a multi-specialty IPA that actually Mitchell has  
7 about 500 physicians at this point. I think it's about  
8 120, 121 primary care docs.

9 We have gone out and employed 50  
10 physicians, not because that's our model. In fact, it is  
11 not. We actually prefer physicians to remain  
12 independent, but if they want to be employed, we'll do  
13 it, so we've hired 50-plus physicians to add to the  
14 network at CharterCARE.

15 We've expanded outpatient clinics beyond  
16 the service area. We've invested in not one, but two  
17 outpatient oncology centers. As earlier noted, we've  
18 achieved academic certification of the Cancer Center. We  
19 provided significant strategic capital.

20 Again, when we talk about capital, we're  
21 talking about the whole network. We're not just talking  
22 about facilities. We don't have an edifice complex.

23 Nevertheless, with respect to facilities,  
24 as someone mentioned earlier today, we're already into

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1 doubling the size of the ER at Roger Williams Medical  
2 Center, expanding services at Our Lady of Fatima,  
3 expanding the GI clinic, and a whole host of other  
4 things, including you can't walk into either hospital  
5 right now, because the facades are being completely  
6 redone, and they're being made appropriate, in terms of  
7 Americans with Disabilities Act and the like, so there's  
8 significant capital being invested.

9 We are implementing the first Medicaid  
10 pilot project in the state, which we're very proud of.  
11 We came to the Governor and suggested it, and we are  
12 going to suggest the same here in Connecticut and have  
13 already started that process.

14 We have the first Blue Cross Blue Shield  
15 risk contract with delegated functions in the history of  
16 Rhode Island, and, so, Les will talk a little bit about  
17 the number of lives we have and what we're going to do to  
18 expand, but we're off to a significant start to really  
19 transform the way health care is delivered in Rhode  
20 Island. We're pretty proud of our accomplishments in the  
21 year and a half, almost two years we've been there.

22 In the quality program, which was  
23 mentioned earlier, I know at the ECHN hearing and I  
24 think, again, today, with respect to the quality program,

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1 one of the things that ECHN folks asked is, okay, when  
2 Prospect came aboard, did you diminish the quality  
3 programs, and what they were told was to the contrary.  
4 Two additional positions were added, so, again, we're  
5 backing the quality programs at CharterCARE. Both the  
6 ECHN and the Waterbury people were very impressed, and  
7 there's a lot of cross-fertilization capabilities, a lot  
8 of cross-huddles that will go on, in terms of higher  
9 reliability.

10 In fact, the Connecticut hospitals are  
11 further along than CharterCARE is, but we're embracing  
12 the whole high reliability model.

13 So why Prospect? If you could move to the  
14 next slide? Oh, you've got it there already. We really  
15 do believe that we provide better community health.

16 Mitchell got into this a little bit, but  
17 we are not a hospital-centered company. We actually are  
18 focused on taking care of the whole patient and getting  
19 sure that that -- making sure that that patient gets the  
20 best care, at the best cost, at the best setting.

21 We will follow the patient into the home.  
22 We're knitting together both physical health and mental  
23 health, which is something nobody really has achieved,  
24 and it's something that needs to be done.

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1           We are empowering local physicians. The  
2 reason we have 500 physicians now at CharterCARE is that  
3 I'd say 30 percent of them came from beyond our initial  
4 service area, had no relationship to CharterCARE, but  
5 because they are now empowered under risk contracts,  
6 they're the ones that determine where patients go and how  
7 people will be paid. They come to the system, because  
8 they love it. The patients love it.

9           In terms of maintaining or creating jobs,  
10 we're a growth company, and, when you get right down to  
11 it, Waterbury Hospital is the largest employer in the  
12 City of Waterbury. There's 1,800 good jobs here. We  
13 need to get this deal done, and we need to preserve those  
14 jobs and grow the system.

15           For too long, St. Mary's and Waterbury  
16 have been focused on each other. We need to look  
17 outward. We need to expand services.

18           In terms of providing resources, I've  
19 often said we bring three things to the table. We bring  
20 capital. There's no question about that. We bring data-  
21 driven management tools, and we bring population  
22 management capabilities, and we're already seeing some of  
23 that benefit at Waterbury, and we'll see a lot more of it  
24 as we go forward.



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1                   Maintaining local leadership, Jon said it  
2 correctly. We believe all health care has to be local.  
3 It can't be delivered from LA. It can't be delivered  
4 where I live up in the Boston area from there. It has to  
5 be local, so we support the local management team and the  
6 local Board.

7                   I've already mentioned investing  
8 significant capital, not just in facilities, but service  
9 technologies across the network.

10                   We preserve charity care policies. In  
11 fact, many of our hospitals are safety net hospitals. We  
12 embrace vulnerable populations. We see that as part of  
13 our mission, and we think we do a heck of a good job with  
14 risk contracts.

15                   A lot of systems, both non-profit and for-  
16 profit, have fled the inner city. Not us. To the  
17 contrary. Our most recent acquisition in East Orange is  
18 urban, urban, urban, safety in that hospital, so we  
19 embrace that capability.

20                   Partnership advantages. Again, as  
21 Mitchell has talked about, right now, what you have is a  
22 fragmented system, and there's an expression about more  
23 heads than beds. The more you do, the more you get paid.

24                   What we're trying to do is put together an

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1 entire network of delivery of care, and it may include  
2 surgery centers. It may include a whole host of things,  
3 community mental health systems, and, so, what we're  
4 trying to do is integrate the entire thing, led by  
5 physicians. That's not to say that Waterbury Hospital is  
6 not going to be part of it. It will be.

7 And, in some ways, it seems counter-  
8 intuitive, because we talk about trying to keep patients  
9 out of the hospital, but what we find, and I've made this  
10 comment before, the CEO of our company, Sam Lee, always  
11 says more and better for less.

12 If you can do a better job and you can do  
13 it for less money, we're going to have more volume, and  
14 that's what we've seen time and time again, and, so,  
15 that's what we do.

16 We really do believe it's better care and  
17 health of the patients, so the patients love it. If you  
18 can treat a patient at home and take care of all their  
19 needs, it really does provide better care.

20 We've mentioned an increased access to  
21 capital and financial strength, and we do think that this  
22 is a sustainable delivery model that will preserve  
23 Waterbury Hospital and physician practices and quality  
24 health care in this community.

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1 I have to give Carl and Darlene  
2 unbelievable kudos. With scotch tape and band aids, they  
3 have continued to provide the highest quality of care, I  
4 mean big time, and that's recognized by national  
5 organizations. It's really very impressive. We want to  
6 maintain that.

7 So why Prospect? To the next one, Jon?  
8 We're committed to Connecticut. Why do we like  
9 Connecticut? As I kidded at the ECHN hearing, it's easy  
10 for me to drive down from Boston, but that's not why  
11 Prospect wants to be here.

12 We like New England, because there's a  
13 couple of things in New England that we think are perfect  
14 for our model.

15 First of all, there's very little managed  
16 care penetration, in terms of real risk contracting. It  
17 starts slowly, but you move the ball, and when we really  
18 get to risk contracting, that makes all the difference,  
19 because once you have 88 cents on the dollar and you can  
20 invest it for preventative care, right now, under fee-  
21 for-service, you have no money to do that, but, under  
22 this model, you can do preventative care, it really is  
23 significant, and, so, there's tremendous amount of  
24 opportunity in Connecticut, as well as New England.

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1 MR. ZINN ROWTHORN: Mr. Reardon, I  
2 apologize for interrupting, but just for purposes of  
3 clarity and for the benefit of the public here, there's a  
4 theme that has developed in your comments about  
5 population management and risk contracts, as opposed to  
6 fee-for-service.

7 It would be helpful if you could give a  
8 very broad overview of what that decision is that you're  
9 making.

10 MR. REARDON: Well Dr. Lew can probably do  
11 that better than me, but let me start. In terms of  
12 population management, what everybody is talking about  
13 right now is getting away from fee-for-service.

14 Right now, the more you do, you more you  
15 get paid, and I gave an example at ECHN, and it's a silly  
16 example, but it illustrates the point.

17 You go to your primary care physician, and  
18 that primary care physician may be the most dedicated  
19 person in the world, and they'll order some tests, and  
20 then you go to a specialist, and that specialist may be  
21 the most dedicated person in the world and cost-efficient  
22 and all the rest, and he or she will order tests, and  
23 then you go to the hospital and you'll get tests, and  
24 then you'll go to the nursing home and you'll get tests,

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1 and what we try to do is integrate all this.

2 In the old days, when we had capitated  
3 payments, it was about denial of care. What we're about  
4 is give us the 88 cents on the dollar, and we'll  
5 coordinate the care across the entire health care  
6 spectrum, and we'll take care of our patient population  
7 that are assigned to us, so that's what I'm talking about  
8 when I talk about population management.

9 Mitchell, do you want to add to that?

10 DR. LEW: Sure. So what Tom described is  
11 a more traditional fragmented type of care, and, with our  
12 model, it's much more coordinated, so, with these  
13 networks that I spoke of, the primary care and  
14 specialists are all part of a network that are talking to  
15 each other through IT and using the same data to access,  
16 so there's not a lot of duplication of services.

17 And, then, through some of these teams  
18 that I talked about, the teams that go to the patients'  
19 homes and the teams that call the patients, we make sure  
20 that there's a proper handoff from the primary care to  
21 the specialist or when a patient goes into the hospital  
22 to the hospital's team and the physicians that see the  
23 patient in the hospital, and then the patient will get  
24 handed over when the patient is transitioned, either to a

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1 lower level of care or back home, and, so, there's a lot  
2 more coordination, there's integration of all of the  
3 providers, there's less duplication, and with our  
4 different payment structure, we do this under a budget,  
5 so that we're watching the dollars that are being spent,  
6 and, so, we can save money out of the health care system.

7 And, so, these are the types of models  
8 that we took, as Tom alluded to, in Rhode Island when we  
9 went to the Governor and we said, Governor, we have a  
10 model of care that can provide the outcomes and the  
11 quality with a savings on your budget, and that's why she  
12 was very excited about approving a Medicaid pilot project  
13 in the state of Rhode Island, and we would love to do  
14 something very similar here, is to develop our model with  
15 the physicians here in Waterbury, and then go to the  
16 state of Connecticut and talk about some of our successes  
17 that we've had in Rhode Island and how we can provide a  
18 better quality of care with savings.

19 MR. REARDON: Let me just add a couple of  
20 quick points, if I can.

21 DR. LEW: Go ahead. Sure.

22 MR. REARDON: Right now, if you look at  
23 what we call metrics, for every 1,000 Medicare patients,  
24 you can expect them to spend collectively X number of

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1 days in the hospital. In Connecticut, my recollection is  
2 it's about 1,400 days in the hospital. With many of the  
3 Prospect hospitals, it's 700 and some days, so think of  
4 the cost savings just there, and yet they're getting  
5 better care at home. They're not risking infection or  
6 any of the rest of the things.

7 The state of Connecticut has adopted a  
8 State Innovation Model that is suggesting that patients  
9 being moved from fee-for-service to population management  
10 or to value-based payment, 80 percent of patients within  
11 just a couple of years, how are they going to do that,  
12 because nobody knows how to do it?

13 I don't mean to be derogatory in that  
14 regard. It takes time to learn how to do this. You  
15 don't learn it overnight. We've been doing it for 29  
16 years, and, in fact, CMS, we've talked a lot about CMS,  
17 is they've tried to get hospitals and other systems ready  
18 for population management.

19 They've come out with something, called an  
20 Accountable Care Organization. The first ones were not a  
21 big deal. It was about shared savings, however, they've  
22 now come out with something called a Next Generation ACO,  
23 where they really will do downside, as well as upside  
24 risk, and only 21 organizations in the United States have

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1 been qualified to do this. Prospect is one of these  
2 organizations. We believe we can be transformative in  
3 the way health care is delivered in Connecticut.

4 And, so, on the last slide, just to wrap  
5 up, we talk about higher quality, higher patient  
6 satisfaction, highest value. It really is the triple  
7 aim. I'm a true believer. I do believe this model can  
8 actually help us get there, and we're excited to be here  
9 partnering with Waterbury Hospital.

10 That concludes our direct testimony.

11 HEARING OFFICER HANSTED: Before we get to  
12 the public comment section, we're just going to take a  
13 five-minute break.

14 (Off the record)

15 HEARING OFFICER HANSTED: Please take a  
16 seat. We want to get going again. Okay, looks like  
17 everyone is almost back. We're back on the record.

18 Just one housekeeping matter. Attorney  
19 Connors, did you have any objection to the Table of  
20 Record?

21 MS. KRISTIN CONNORS: No. Kristin Connors  
22 and Ann Zucker from Carmody Torrance Sandak & Hennessey  
23 on behalf of Greater Waterbury Health Network, and we do  
24 not have any objection to new Exhibit S. I'd just like



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1 to note that there's over 110 letters of support. It  
2 looks like it's one exhibit.

3 HEARING OFFICER HANSTED: Okay, thank you,  
4 Attorney Connors. And now we're ready to move to the  
5 public comment section of this afternoon's hearing.

6 (Whereupon, the public spoke.)

7 HEARING OFFICER HANSTED: Okay. At this  
8 point, OHCA has some questions. Ms. Cotto, if you want  
9 to begin? Kim? Go ahead.

10 MS. MARTONE: Hi. Kim Martone, OHCA  
11 staff. We're going to do this a little bit differently  
12 today, as opposed to going through and asking you  
13 questions, at least from my part.

14 What I'd like to do is kind of summarize,  
15 particularly for Prospect, things that we've discussed in  
16 prior hearings, things that we've, you know, had  
17 agreement on, things that have been thoroughly discussed,  
18 so we're not going to go through it again today.

19 What I'm going to ask Prospect to do is  
20 just confirm agreement, or if you have a question, we can  
21 discuss it again, but these are things that we discussed  
22 at the ECHN/Prospect hearing, and it's really for them,  
23 just to go over it. It's for the community and the  
24 public to know what's been discussed, and things that

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1 have been agreed upon, and our assumption would be the  
2 same thing, would be agreed upon for the purchase of  
3 Waterbury Hospital, if approved.

4 Okay, so, the first item that we discussed  
5 was the community health needs assessment. We had  
6 discussions regarding if Prospect has done -- conducted  
7 in other states, if it was the same as the federal  
8 government requires for not-for-profit hospitals, and I  
9 would just like the Applicant to confirm that they will  
10 participate and they would conduct with the community.

11 We heard testimony today, or a couple of  
12 the comments from the community action agency from Easter  
13 Seals, other health organizations in the community, so  
14 would you confirm that you would work with these  
15 community stakeholders, with representatives from the  
16 medically-underserved populations in conducting the  
17 community health needs assessment or study for the  
18 Waterbury area?

19 MR. CROCKETT: Yes. We've discussed this  
20 in detail with Waterbury, and our understanding is they  
21 are currently participating in the Greater Waterbury  
22 Health Improvement Partnership, and Prospect has agreed,  
23 in conjunction with Waterbury, to go forward, and we'll  
24 do the commitment for a five-year period at the same

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1 participation level that they're currently participating  
2 in.

3 MS. MARTONE: Can I ask why only for a  
4 five-year period?

5 MR. CROCKETT: It was simply matching it  
6 up with our other commitments within the asset purchase  
7 agreement.

8 MS. MARTONE: Okay, well, we also have  
9 questions about why there's a five-year commitment on  
10 others, but we'll just leave it at that at this point.

11 Something new, based on public comment  
12 that was given today and because we are the Department of  
13 Public Health, the importance of aligning these community  
14 health needs assessments with Healthy People 2020, as  
15 well as the Department's health improvement plan.

16 I would assume that you would confirm  
17 that, as well. When you're looking at a community health  
18 needs assessment, you would be looking at state and  
19 federal health plans, as well.

20 MS. VOLPE: Can you give them some  
21 additional information on what you just stated, because I  
22 don't believe that has been ever discussed.

23 MS. MARTONE: No. That's why I'm bringing  
24 it up now. So in terms of a community health needs

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1 assessment, you know, the federal government doesn't  
2 really have standards or guidelines by which have to be  
3 followed, so, at the state level, we're looking at having  
4 these community health needs assessments really align  
5 with Healthy People 2020.

6 MS. VOLPE: Which is what? Healthy People  
7 2020?

8 MS. MARTONE: Healthy People 2020, Healthy  
9 Connecticut, they're statewide and national plans that  
10 look at chronic disease and obesity and, you know, areas  
11 of significant concern for populations, so we would want  
12 to align with those goals, and we also have a Department  
13 State Health Improvement Plan, which aligns with Healthy  
14 People 2020, as well, which goes to the public comment,  
15 as well, that was given today.

16 MR. SPEES: Wouldn't that be something  
17 that would be decided by that larger group, of which  
18 we're only part?

19 MS. MARTONE: The larger group? I'm  
20 sorry?

21 MR. SPEES: The Greater Waterbury Health  
22 Improvement Group?

23 MS. MARTONE: Yes. Our hope would be that  
24 Prospect will be part of that participation, part of that

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1 community needs assessment, but with you as the  
2 purchaser, we want to confirm that that will be done.

3 MR. CROCKETT: We'll confirm our  
4 participation in the process if that's accurate.

5 MS. MARTONE: Thank you. The second area  
6 that was discussed and public comment was given and the  
7 importance of having an independent monitor, so we had  
8 talked about Prospect retaining the independent monitor  
9 for a certain length of time, possibly three years.

10 That monitor would report to OHCA. They  
11 would really look at the compliance of any conditions  
12 that came from an approval of this proposal.

13 MR. REARDON: We are open to that, as we  
14 said at the previous hearing. What we want to make sure,  
15 I mean, we can be talking about hundreds of thousands of  
16 dollars of expenditures.

17 We wouldn't want to see an independent  
18 monitor for OHCA, an independent monitor for the  
19 licensure division, an independent monitor for the OAG,  
20 etcetera, etcetera.

21 MS. MARTONE: Understood.

22 MR. REARDON: Okay.

23 MS. MARTONE: The next area was a three-  
24 year service plan. There is a statute that does require

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1 other proposals to provide a three-year service plan to  
2 OHCA, so we want to confirm that service plan, that you  
3 could confirm that a service plan would be submitted to  
4 OHCA, in terms of any consolidation, reduction,  
5 termination of service, expansion of services, going  
6 along with the timeline with the community health needs  
7 assessment.

8 MS. VOLPE: So, in terms of that,  
9 obviously, there's a fair amount of statutory and  
10 regulatory oversight when you want to terminate a  
11 service, add a service, so, of course, (coughing).

12 Are you suggesting something beyond what  
13 statutory (indiscernible - too far from microphone).

14 MS. MARTONE: Yes, a service plan, a  
15 three-year service plan to meet the Waterbury community's  
16 needs.

17 MS. VOLPE: So, as Mr. Crockett explained,  
18 so if we're working with the Greater Waterbury Health  
19 Network partnership and a community health needs  
20 assessment is done, is determined, based on that  
21 community and what's needed, are you suggesting that this  
22 would be something different and separate from that?

23 MS. MARTONE: Yes.

24 MS. VOLPE: Okay and I think we need to

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1 have a better understanding of what's involved with that  
2 before we can respond to that.

3 MS. MARTONE: Well it's not really what's  
4 involved. It's just confirmation that there would not be  
5 an issue with submitting a service plan to OHCA, in terms  
6 of any, like I said, any change in services that is being  
7 contemplated.

8 HEARING OFFICER HANSTED: Right, so,  
9 without getting into specifics, is there any objection  
10 to, at some point, submitting a written three-year plan  
11 of how PMH and Waterbury Hospital will proceed with  
12 respect to the services offered to the community?

13 MS. STROMSTAD: I would just like to ask  
14 this question or state what to me is sort of obvious. We  
15 wouldn't want to make public strategic plans that put us  
16 on -- that kind of play our competitive hand.

17 HEARING OFFICER HANSTED: Right. We're  
18 not asking for anything confidential or strategic.

19 MS. VOLPE: So this is something that --  
20 is it a reporting obligation you receive from other  
21 hospitals?

22 MS. MARTONE: Not at this time. We  
23 haven't received one yet. Let's put it that way.

24 MS. VOLPE: So this would be a new

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1 requirement imposed on a hospital in Connecticut?

2 MS. MARTONE: On hospital acquisitions and  
3 conversions, correct.

4 MS. VOLPE: So is there a sample of it?

5 MS. MARTONE: No, we don't have a sample  
6 of it. It's really up to -- it's your plan. It's  
7 whatever is developed.

8 MS. VOLPE: Right, but, as Darlene said,  
9 to the extent that it does contain -- I mean,  
10 fortunately, it's a two-hospital town, you know, but we  
11 wouldn't want to be disadvantaged from, you know, our co-  
12 city hospital, to the extent that we're divulging a  
13 three-year plan to you that we feel is important to  
14 implement, so I think you need to appreciate that, and we  
15 need to absorb what you're saying, because it isn't  
16 something that's already, you know, active here in  
17 Connecticut.

18 HEARING OFFICER HANSTED: We'll leave this  
19 open for further discussion.

20 MS. VOLPE: Thank you.

21 MS. MARTONE: Also, discussion over the  
22 capital investment plan and a timeline for capital  
23 projects. Public comment was given today about  
24 renovating the emergency department, about new



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1 technology, so, if not available at this time, we would  
2 be looking for you to submit some type of capital  
3 investment plan.

4 MR. SPEES: Yeah. We fully intend to  
5 honor the commitment that we're making with respect to  
6 the capital commitment, and we're happy to provide, you  
7 know, details of the capital investment plan, as it's  
8 developed.

9 The important part of that is that we'll  
10 have to be flexible, because, as has been discussed many  
11 times today, that things are changing pretty rapidly,  
12 and, so, I don't think it would be in anyone's interest  
13 to fully commit in a binding way the entirety of the  
14 capital commitment, because that would eliminate any  
15 opportunity to respond to change in circumstances, so  
16 we're happy to share with you sort of in general terms  
17 where we expect the capital to be deployed.

18 MS. STROMSTAD: I just wanted to say I  
19 think we did submit a list, a simple list of some life  
20 safety issues and other major global service priorities.

21 MS. MARTONE: Yes. We also discussed  
22 maintaining current policies, charity care policies for  
23 the indigent population, community volunteer, community  
24 benefit policies, so we're looking for confirmation that

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1 that would be held, as well, for this proposal.

2 MR. CROCKETT: Could you repeat the  
3 question, please?

4 MS. MARTONE: Maintaining current  
5 policies, such as charity care policies that are offered  
6 by Waterbury for the indigent population, community  
7 benefit activities that are currently being offered,  
8 community volunteer activities that are currently being  
9 offered, so we're looking for maintaining those or  
10 enhancing them.

11 MR. CROCKETT: Three parts, in terms of  
12 the charity care, the second part the community benefit,  
13 and the third is the volunteer.

14 As are stated in our APA, that we will  
15 maintain the charity care policies, and, so, yes, the  
16 confirmation associated with that.

17 The second part was the community benefit  
18 program. As was testified today, part of the community  
19 benefit that currently Waterbury is given is grant  
20 related, and the Ryan White was an example of that, and  
21 some of those funds, in some of those instances, the  
22 funds can be transferred to a for-profit and, in other  
23 instances, they're not able to.

24 Waterbury is in the process of

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1 transferring those that are not able to be transferred to  
2 a for-profit to other organizations, and we're supportive  
3 of that, as well. For those areas that Waterbury can  
4 continue to receive the grant funds for, then Prospect  
5 will continue those community benefits associated with  
6 that.

7 MS. MARTONE: That's fine, and then we  
8 would just ask for a list of the community benefit  
9 activities that would be continued, if you receive the  
10 grants for that money.

11 MR. CROCKETT: Correct. As it relates to  
12 the volunteer, Jon, you can correct me if I'm wrong, but  
13 I believe that we're going to continue in the same  
14 fashion.

15 MR. SPEES: Well, actually, we would love  
16 to be able to continue the volunteer program, but we  
17 actually believe that it may be challenging to receive  
18 the services of volunteers as a for-profit entity, so  
19 we've been looking at ways that we may be able to  
20 continue the volunteer services, but we may actually be  
21 precluded by the employment law from doing so.

22 MS. MARTONE: That's understood.  
23 Precluded from that. But, also, the concern is the five-  
24 year limit and why you would only maintain the policies

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1 for five years, unless you were going to increase the  
2 policies after five years.

3 MR. CROCKETT: Once again, it was to match  
4 up to the APAs related to the commitment of services and  
5 to be consistent throughout.

6 MS. MARTONE: Okay. Also, we had  
7 discussions and there's public comment regarding having a  
8 community ombudsman on board to truly represent the  
9 community, especially on the local Board, so is there a  
10 concern that Prospect has with having a community  
11 ombudsman on the local Board representing the community?

12 And it sounded like from public comment  
13 today they would really like a more diverse Board and  
14 really representing the people in the community.

15 MS. VOLPE: Can I just ask for a point of  
16 clarification? So the community ombudsman, if they were  
17 on the Board, serving as a Director on the local Board,  
18 what different or additional role would they have as an  
19 ombudsman?

20 MS. MARTONE: I don't think it would be a  
21 different role. It would just be someone, who was truly  
22 picked from the community, not by the hospital, not by  
23 members of the hospital. Maybe a First Selectman would  
24 decide a community member to be on the Board.

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1 MS. VOLPE: So I think we're open to it,  
2 but, again, who would be selecting that person? We  
3 talked a lot about the composition of the local Board, so  
4 that's what I'm saying. Are you asking for a community  
5 Board person?

6 MS. MARTONE: Yes.

7 MS. VOLPE: And, so, their role would just  
8 be to serve as a Board selected from what in the  
9 community? What's the --

10 MS. MARTONE: Correct. Like I said, it  
11 could be by the First Selectman. It's someone, who is  
12 representing the community truly and representing their  
13 needs and bringing that to the Board and bringing that  
14 back to the community.

15 MS. STROMSTAD: Could I just comment on  
16 this? I think that the present Board of Directors of the  
17 Greater Waterbury Health Network would all say they  
18 represent the community.

19 First of all, you want to have, you know,  
20 a good cross-section of Board members, which I believe we  
21 do. These people have volunteered for years. They give  
22 up their time and are very concerned about the delivery  
23 of health care, so I think they are truly representatives  
24 of the community.

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1           The other thing that I think is really  
2 important to recognize is that your Board needs to come  
3 as great advisors, so we give a lot of thought to the  
4 makeup of our Board. Not all of them are the same. They  
5 are different. They come in with different perspectives,  
6 different skills, and having that healthy balance for  
7 your Board is really important.

8           I'm a little concerned about, you know, a  
9 wider body just kind of like saying take this person,  
10 when it really needs to fit into the overall Board and  
11 skill set that we need. It could work.

12           MS. MARTONE: Okay. That's fine. Okay  
13 and the last area that has been discussed at other  
14 hearings is having an annual public forum, and that would  
15 be held yearly, and Prospect would attend, and it would  
16 give the public an opportunity to voice any concerns and  
17 issues, as well as give Prospect an opportunity to share  
18 with the community their activities, and Prospect did  
19 confirm that at a previous hearing.

20           MR. CROCKETT: That's confirmed, yes.

21           MS. MARTONE: Okay.

22           MR. REARDON: I'd just like to make one  
23 correction. Mr. Rawlings kind of made a comment that we  
24 didn't want to talk to the community, and I think that's,

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1 in all due respect, a total mischaracterization.

2 We've met a couple of times, as Steve  
3 Shrag and Reverend Thompson said, with Naugatuck Valley  
4 and with the community, and we're glad to keep meeting  
5 with them. We're glad to have input from them and meet  
6 with the NAACP.

7 We have many of the same goals. In fact,  
8 as you go down the list, they're almost all the same.  
9 Our concern had been signing specific agreements with a  
10 multiple set of groups, beyond having an agreement with  
11 ALCO(phonetic) which could be enforced, and conditions  
12 from the State and working with our Adviser Board.

13 MS. MARTONE: We understand that. Thank  
14 you. Okay. Steve?

15 MR. LAZARUS: All right. Steve Lazarus.  
16 I just have a couple of questions. Can you confirm that  
17 in the draft APA it was stated that the Applicants will  
18 follow the same general community benefit standards, and  
19 those would include -- they would participate in the  
20 Medicare and Medicaid program and accept all Medicare and  
21 Medicaid patients, accept all emergency patients, without  
22 regard of ability to pay, maintain an open medical staff,  
23 and provide public health programs and education benefits  
24 to the community and generally promote public health

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1 wellness and welfare to the community?

2 MR. REARDON: That's confirmed.

3 MR. LAZARUS: Okay, thank you. And really  
4 my last question is can you confirm that PMH would spend  
5 one percent more than the amount of what Waterbury  
6 Hospital spent in fiscal year 2014 for the first three  
7 years of post-closing in both the financial assistance  
8 and certain other community benefits at the cost and the  
9 community building activities?

10 MR. SPEES: Yeah, that's not part of the  
11 APA, and we've had this conversation. I just want to  
12 clarify, because we're talking about terms that are very  
13 similar sounding.

14 There's community building, there's  
15 community benefit, and they're significantly different,  
16 so if you're referring to the community building  
17 activities, that answer would be yes.

18 MR. LAZARUS: What about the financial  
19 assistance and, also, certain other community benefits?

20 MR. SPEES: Well didn't we talk about the  
21 community benefits, that we would provide a list that you  
22 asked for of those programs that would continue?

23 MR. LAZARUS: So the one percent that you  
24 have referred to, that was only for the community



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1 building activities, in reference to that?

2 MR. SPEES: Correct.

3 MR. LAZARUS: Okay, nothing else?

4 MR. SPEES: Well we've committed to  
5 maintain the charity care policies, and, so, as part and  
6 parcel of that would be community -- a significant amount  
7 of community benefit there. We've committed to maintain  
8 the clinical services, which are significant, and we've  
9 talked about providing a list of the other types of  
10 community benefit services that we expect to continue, so  
11 I'm not sure what we're missing in that group.

12 MS. MARTONE: I think we're just trying to  
13 distinguish between the two, as well.

14 MR. SPEES: Yeah.

15 MS. MARTONE: And it's important to the  
16 Department that community benefits are made a priority in  
17 this proposal. We realize the fact that you might not be  
18 able to provide some of them, because there might be a  
19 grant issue, but it is very important that the community  
20 benefit activity that has taken place over the years that  
21 Waterbury has done we would like to have that maintained,  
22 if not, improved, but maybe you'll be improving it in  
23 other areas, because of the grants that you receive, so  
24 that's something we would need to look at.

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1 MR. LAZARUS: So just confirming, this is  
2 for a three-year period, not a five-year period?

3 MR. SPEES: Correct.

4 MR. LAZARUS: In this instance.

5 MR. SPEES: Correct. Still, though, I'm  
6 not clear on exactly what commitment you're looking for,  
7 because of the nature of the language around what  
8 constitutes a community benefit and what constitutes  
9 community building, and I'm concerned that it's overly  
10 broad.

11 MR. LAZARUS: So it's something that we'll  
12 have to clarify as we move forward?

13 MR. SPEES: Yeah.

14 MR. LAZARUS: All right, thank you. I'm  
15 going to turn it over to Carmen for some financial  
16 questions.

17 MS. CARMEN COTTO: Carmen Cotto, and I'm  
18 going to direct my questions mainly to Mr. Aleman and Mr.  
19 Spees.

20 My first question is related to we had  
21 asked you to provide us some information related to some  
22 issues prior to this hearing, and I'm just going to ask  
23 you a question related to your responses on those issues  
24 that we received last week.

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1           The first one is related to issue number  
2 two. That's on page one and three of your responses from  
3 last week on April 27th. It's with respect to the  
4 pending purchase of Crozer-Keystone Health System in  
5 Pennsylvania. We just wanted to ask you does PMH  
6 anticipate to close that transaction, ECHN transaction  
7 and Waterbury transactions, approximately at the same  
8 time? When would you intend to close those transactions?

9           MR. ALEMAN: I would anticipate those  
10 would all be closed certainly within the next 120 days.  
11 Crozer-Keystone in Pennsylvania is going through the  
12 regulatory review process, as well. They're all on -- I  
13 think you're certainly aware of the timelines between  
14 Waterbury and ECHN. Crozer-Keystone we anticipate  
15 closing early summer.

16           MS. COTTO: Early summer. And, then, for  
17 ECHN? Do you have an estimate of the closing days?

18           MS. VOLPE: So we're expected to receive  
19 final approval on or about June 10th, but we still have  
20 to get licensed, all in the facility have to get  
21 licensed, so that isn't within your control or ours  
22 necessarily, so some of the closing date is going to be  
23 dictated by how quickly we can get the licensure  
24 applications complete and reviewed and gone through at a

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1 separate division of your department, so, in terms of a  
2 definitive close date, I think everybody wants it as soon  
3 as possible. Prospect does, Waterbury does, ECHN does,  
4 but I think, in reality, some of it is going to be  
5 dictated by the regulatory process, so I think we can  
6 certainly say, upon regulatory approval, all regulatory  
7 approvals, AG, OHCA, licensure, you know, we can commit  
8 to some time period thereafter.

9 HEARING OFFICER HANSTED: It's fair to  
10 say, just for these discussion purposes, that  
11 Pennsylvania will close a good amount sooner than  
12 Connecticut, if approved.

13 MR. ALEMAN: I've come to learn you never  
14 know.

15 HEARING OFFICER HANSTED: Right. I won't  
16 hold you to it.

17 MR. ALEMAN: Right now, it's currently  
18 anticipated to do so, and let me just kind of take it to  
19 the next step. When all transactions from a regulatory  
20 standpoint were able to close, we have the financial  
21 wherewithal to close on all three, so there's no concerns  
22 on that behalf from our standpoint.

23 MR. SPEES: But just to make sure, there's  
24 more than just regulatory to closing a transaction, so we

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1 also have lots of contracts to get assignments on, and we  
2 have get payer contracts, and we have to get landlords to  
3 consent to assign leases, so it's a very significant  
4 amount of work, and we are holding weekly meetings, and,  
5 as Michelle said, we're trying to move as quickly as we  
6 can to be in a position to close, and they are all sort  
7 of lining up to be approximately the same closing  
8 schedule, but it would be hard to predict the exact date.

9 HEARING OFFICER HANSTED: Let me boil this  
10 down really to a pinpoint here. If all of these  
11 transactions were to close on the same day, would there  
12 be a financial constraint for PMH?

13 MR. ALEMAN: The answer is no.

14 HEARING OFFICER HANSTED: Thank you.

15 MR. SPEES: It would be a challenge.

16 MR. ALEMAN: A logistical challenge, not a  
17 financial challenge.

18 DR. LEW: But a no.

19 MR. SPEES: I can actually predict that  
20 that will not occur.

21 HEARING OFFICER HANSTED: I'm sure I  
22 could, also.

23 MS. COTTO: Okay. With that said, then  
24 could you provide us with a report that states how these

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1 transactions will be financed, a specific report that  
2 states how it will be financed, and shows that you really  
3 don't have a problem financing these closings?

4 MR. ALEMAN: Sure.

5 MS. VOLPE: So would that be Late File No.  
6 1?

7 HEARING OFFICER HANSTED: That will be  
8 Late File No. 1.

9 MS. COTTO: Okay. Let me see. I have  
10 another question on issue number five, page six and 38.  
11 The responses indicated that -- let me give you the exact  
12 statement. It indicates that there are several grants  
13 that will continue to flow directly to post-closing  
14 Waterbury Hospital.

15 Our request is could you provide us a list  
16 of those grants that will flow directly to Waterbury  
17 Hospital post-closing?

18 MR. ALEMAN: Yes.

19 MS. COTTO: Okay.

20 HEARING OFFICER HANSTED: That will be  
21 Late File No. 2.

22 MS. VOLPE: So just for point of  
23 clarification, the list of grants that would flow to  
24 Waterbury Hospital post-closing or pre?

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1 MS. COTTO: Post-closing.

2 MS. VOLPE: Post-closing?

3 MS. COTTO: Yeah. I just have things to  
4 clarify, in terms of the numbers. To the letter of  
5 intent that you submitted in April in 2015, the purchase  
6 price shows \$45 million. Through the APA, the draft that  
7 we have on file, indicates 31.8 for the purchase price,  
8 and, today, you're back to the 45 million. I just want  
9 to confirm is it 45 million, the purchase price?

10 MR. SPEES: Yeah. The difference there is  
11 the working capital, so it's 31.5, plus the value of the  
12 working capital at closing, and that fluctuates from  
13 month-to-month, but, based on the most recent month, it  
14 actually pencils to slightly more than \$45 million, so  
15 that's the difference in those two data points.

16 MS. COTTO: Correct, because the APA  
17 indicates, though, that it's 31.8, plus the net working  
18 capital.

19 MR. SPEES: Correct.

20 MS. COTTO: And, as of September 31st, it  
21 was at 4.6, so I'm just trying to get to the -- so what  
22 you're saying is, between the time that you finalized,  
23 gave us, produced a draft of the APA in October and as of  
24 today, then the net working capital has changed that much

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1 and increased from 4.6 to the difference between the 31.8  
2 and 45 million? Is that what you're saying? I'm just  
3 trying to clarify the difference here.

4 MR. SPEES: Sorry. I'm not following the  
5 dates and data points. So the working capital changes on  
6 a monthly basis, and it could swing, you know, millions  
7 of dollars between one month and the next month.

8 MS. COTTO: Okay.

9 MR. SPEES: And the purchase price is  
10 dollar-for-dollar, based on what that value is.

11 MS. COTTO: So it fluctuates that fast?

12 MR. SPEES: It does fluctuate a fair  
13 amount.

14 MS. COTTO: Okay, so, it is 45 million.  
15 And the capital commitment is still seven years, because  
16 I heard five years in other --

17 MR. SPEES: This transaction is seven  
18 years.

19 MS. COTTO: Seven years for the capital  
20 commitment?

21 MR. SPEES: That's correct.

22 MS. COTTO: Could you provide us with an  
23 update on the joint venture's interest? Have the  
24 transfers finalized?



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1 MS. STROMSTAD: Yes, we'll do that. We'll  
2 confirm that we have all the consents from our joint  
3 ventures. Is that what you're asking?

4 MS. COTTO: Yes. I'm just wondering if  
5 they're already done, as of today, or are you still  
6 waiting?

7 MS. STROMSTAD: No. We still have some  
8 Board meetings that are going on.

9 MS. COTTO: You are?

10 MS. STROMSTAD: Yes.

11 MS. COTTO: Okay, thank you. And then,  
12 for PMH, what's your credit rating, as of right now?

13 MR. ALEMAN: It hasn't changed.

14 MS. COTTO: It hasn't changed since last  
15 year?

16 MR. ALEMAN: That's correct.

17 MS. COTTO: 2015?

18 MR. ALEMAN: That's correct.

19 MS. COTTO: So it's still B?

20 MR. ALEMAN: B.

21 MS. COTTO: B-1 plus?

22 MR. ALEMAN: Yes.

23 MS. COTTO: Okay and could you provide us  
24 with an updated version of the net proceeds and flow of

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1 funds calculation that you have provided to us on page  
2 1419? That one is only until September 30th.

3 We need you to provide us with a revised  
4 version, the same way that you did for ECHN, because we  
5 received a revised version, with two columns that  
6 indicates 9/30/15 numbers, and then the most recent  
7 numbers for March.

8 MR. ALEMAN: Yeah, we can do that.

9 HEARING OFFICER HANSTED: That would be  
10 Late File No. 3.

11 MS. VOLPE: So you want an update to Bates  
12 stamped Exhibit 1419?

13 HEARING OFFICER HANSTED: Correct.

14 MS. COTTO: Right. Yeah. Just update  
15 that one, and include two columns. Still keep the 9/30,  
16 and then also add as of March 1st, like you did for ECHN.  
17 Same request.

18 MR. ALEMAN: That's fine.

19 MS. COTTO: And that's it. That's it for  
20 me. No more questions. My apologies. I'm sorry. My  
21 apologies. I do have another document here, but it's not  
22 this long. It's just two questions. I'm sorry.

23 In the testimony on page 1628, 29, you  
24 talk about, and you talked about it through the

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1 presentation, about the amendments to the APA and the LOI  
2 to favor Waterbury, to help Waterbury to this proposal.

3           Could you tell us when could you file that  
4 to us, a copy of that? Because you indicated that would  
5 be filed to OHCA.

6           MR. SPEES: Yeah, so, we just received a  
7 draft of the amendments last Friday and haven't had much  
8 chance to focus on it, but I would say within a couple of  
9 weeks we should be able to finalize that, if that's  
10 acceptable?

11           MS. COTTO: Okay.

12           HEARING OFFICER HANSTED: That will be  
13 Late File No. 4.

14           MS. VOLPE: And there's just a question  
15 about clarification. You're looking for any changes that  
16 may occur to the APA or the LOI?

17           MS. COTTO: Correct.

18           MS. VOLPE: The amendment to the LOI and  
19 any change to the proposed draft?

20           MS. COTTO: Correct.

21           HEARING OFFICER HANSTED: Correct.

22           MR. SPEES: Yeah, and I think,  
23 technically, we have to amend the LOI to attach the new  
24 APA.

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1 MS. VOLPE: Very good.

2 MS. COTTO: I'm done. I'm all set. Thank  
3 you very much.

4 HEARING OFFICER HANSTED: We're all set.

5 MR. ZINN ROWTHORN: Okay. We're going to  
6 try very hard to not duplicate what's been asked already,  
7 either here or in other hearings. Attorney Salton, do  
8 you have some questions?

9 MR. HENRY SALTON: Yeah, I do. I have a  
10 couple of questions regarding the capital commitment, the  
11 reinvesting in the community.

12 The time frame for completing the capital  
13 commitment investment in the community for ECHN is five  
14 years. The Waterbury application indicates seven years.  
15 Can you explain why there's a difference in the two  
16 commitment periods?

17 MS. STROMSTAD: I can explain that. Our  
18 transaction with whoever was first was seven years, and,  
19 when we started our discussions with Prospect, we just  
20 adopted the same thing, and the reason it was seven years  
21 is that we felt that we didn't want to be pushed to spend  
22 money before we were ready to implement it.

23 There's nothing that you can do wrong.  
24 I've been in this industry for a long time. To implement

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1 something that you throw a great deal of investment in  
2 and then don't have the time and the intention to make it  
3 work for you, so we were very comfortable with the first  
4 transaction of taking that bullis of money and spending  
5 it over seven years.

6 MR. SALTON: Okay. There were some  
7 comments earlier today about the condition where there's  
8 an adverse -- legal requirements adopted that's  
9 prejudicial for profits, and, in the application, unlike  
10 ECHN, which provides for a deferral of the investment,  
11 your agreement in the application indicates that you can  
12 base they're relieved of your commitment, and then  
13 there's a process for coming to some mutual agreement,  
14 and I just want to get clarity on what your position is  
15 on that provision now.

16 You're going to just look at what we're  
17 going to suggest, or are you standing by that, because  
18 there's a significant difference between those two  
19 positions?

20 MR. SPEES: Yeah, so, just to clarify,  
21 recognize that the language in the Waterbury purchase  
22 agreement is more broad, in terms of being able to be  
23 relieved of the capital commitment, and, as I testified  
24 earlier, we're willing to not have any relief from the

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1 capital commitment, so that it would be a firm dollar  
2 commitment.

3 In addition, in neither agreement is there  
4 a specified time over which the capital commitment could  
5 be deferred in that circumstance, and we're open to  
6 limitations on the time commitment that that capital  
7 commitment could be deferred.

8 MR. SALTON: Okay. Moving to the quality  
9 improvement program, because I don't want someone, who is  
10 new to the entity, not have a chance to speak.

11 I'm actually going to ask the first  
12 question to the President and not to you. So this is a  
13 draft program that I guess was submitted initially April  
14 20th with the late filings for ECHN. What is the  
15 company's perspective on their commitment to this  
16 program? Is this something that's sort of just it's an  
17 idea that's out that we're looking at, or is there a  
18 commitment to going forward with this, or is there major  
19 revisions on off stage coming forward?

20 DR. LEW: Sure. I'll speak generally to  
21 this, Henry, and then, if Von wants to add anything. So,  
22 you know, we brought in Debbie Berry, because of her  
23 credentials, and she shared her expertise in prior  
24 dialogue, and she also shared what she referred to as the

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1 draft and the outline of what our commitment is going to  
2 be, so our commitment is that's a start, okay?

3 Our commitment is to build on that, and,  
4 as you've heard, we support the current effort at Greater  
5 Waterbury in their efforts to be a high-reliability  
6 organization, and, as I shared with you the last time we  
7 met, how I was embarrassed.

8 And the fact that we were moving  
9 directionally, as Von shared with LA, in having the  
10 conditions relieved, we've made significant progress  
11 already in California and now with the addition of Debbie  
12 to set a path for us to excellence.

13 And to share a line from Neil, who was  
14 very colorful in his presentation, to be great, and  
15 that's our commitment.

16 If you want anything specific, I can have  
17 Von speak to it.

18 MR. CROCKETT: Yeah. We've actually --  
19 the word draft is really meant more in terms of, once we  
20 start working closer with ECHN and Waterbury and  
21 potentially the Philadelphia organization, as well, then  
22 we would fine tune the organizational chart.

23 We've already started actually filling the  
24 positions within the draft that you've already seen, and

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1 I anticipate that, with Dr. Lew's support and others, the  
2 program will be adopted, and it would only be minorly  
3 tweaked.

4 MR. SALTON: So, at the corporate level,  
5 we should see this, if not, some additional improvement  
6 on what's been submitted?

7 MR. CROCKETT: That's correct.

8 MR. SALTON: Okay and looking at what  
9 you've presented, as far as you're talking about  
10 substantial data systems and collection, integration of a  
11 dashboard, lots of staff, is there a financial commitment  
12 by the company to implement all of these things?

13 DR. LEW: Yes.

14 MR. SALTON: Okay and I notice that you've  
15 submitted CVs for three folks, and I understand, Debbie,  
16 what you're going to be doing, what who are the other,  
17 what are the roles of the other folks going to be in this  
18 org chart, as far as which positions are they going to  
19 hold, so that we know whose credentials we're looking at?

20 You want the names? One is Candace  
21 Peters.

22 MS. BERRY: Candace Peters, she is  
23 assigned as the AVP of Regulatory and Accreditations.  
24 She's probably going to move under that VP Regulatory and



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1 Accreditation for our clinical practice person. I don't  
2 know that yet, but she's going to move within that  
3 position. What other positions? Oh, Thedosia. Oh, I'm  
4 very excited about Thedosia. She is our Senior CNO. One  
5 thing that I'm very committed to is improving the  
6 clinical excellence of our nursing practice, so Thedosia  
7 is going to lead that up for the organization. I met  
8 with her the first time. Very impressed.

9 MR. CROCKETT: And, for clarification on  
10 the org chart, that box doesn't exist right now. We're  
11 going to be adding it in, and that's part of the minor  
12 modification to the program that I was speaking to.

13 MS. BERRY: Yeah.

14 MR. SALTON: Okay.

15 MS. BERRY: Because, at the time I created  
16 that, I had not met yet with Thedosia. I can never say  
17 her name right. Thedosia. So I didn't put her in there,  
18 but I'm very excited about that role.

19 MR. SALTON: In the org chart that is the  
20 corporate officers for Quality, how many of those  
21 positions are filled?

22 MR. CROCKETT: At the moment, you know, we  
23 haven't spoken with the individuals that I think  
24 clarified it with them, but we anticipate, Debbie and I,

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1 that two of those positions are going to be filled with  
2 staff in-house, then we'll be looking within either the  
3 ECHN, Waterbury and Crozer facilities in filling the  
4 other roles, and, if not, then looking external, but we  
5 anticipate two of those roles will be filled internally.

6 MR. SALTON: Okay, so, in the org chart  
7 and in the materials you submitted, there are these  
8 councils. What's the relationship between the local  
9 Board, which has Quality Assurance responsibilities, and  
10 these councils? I'm not sure the councils are part of  
11 the corporate entity, or they're perceived as being  
12 within the hospital.

13 MS. BERRY: That would flow up into, that  
14 local quality would flow up into the regional.

15 MR. SALTON: So is the council different  
16 from the local Board?

17 MS. BERRY: At the time that I created  
18 this, I didn't know that there was a local Board. Pretty  
19 much, your local Board is going to go through your  
20 Quality, 3 MAC 3 Board (phonetic), and it will go up to  
21 the regional, and then to the company.

22 MR. SALTON: If you guys have a vision of  
23 how you're going to revise this, I know this was a  
24 preliminary draft and now you know the local Boards are

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1 there, could you guys submit an updated organizational  
2 chart, so we can make sure that we understand?

3 In addition, I assume that the late  
4 filings that were done in ECHN 1410, three of those  
5 things that describe the program, those are going to  
6 carry over to Waterbury?

7 MS. BERRY: Um-hum.

8 MR. SALTON: So to the extent there's some  
9 update to make sure that everything is integrated,  
10 because you have now the commitment letter, which we got  
11 today.

12 MR. ZINN ROWTHORN: Yeah and I'll just  
13 mention we have left the record open indefinitely with  
14 respect to the immediate jeopardy matter, so that we can  
15 have all documents related to those be submitted.

16 I think you should consider, with respect  
17 to amendments to the organizational chart, as that  
18 evolves over time, that our record will remain open for  
19 that, so we'll have the most current information up  
20 through our time of decision, if that's okay.

21 MR. CROCKETT: That's acceptable.

22 MR. ZINN ROWTHORN: Thank you.

23 MR. SALTON: Part of what you proposed is  
24 a gap analysis at the local hospitals. Do you have a

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1 sense of when that's going to take place, and then would  
2 a gap analysis be presented to the local Board?

3 MS. BERRY: Those are based on, when I  
4 spoke to the gap analysis, those were based on  
5 initiatives. For example, if we wanted to decrease  
6 pressure ulcers, we would bring together a work team,  
7 where that work team comes in with folks, who are experts  
8 in wound care, folks that are as close to the bedside as  
9 we can get, then they would write an initiative, create  
10 an initiative that has a tool kit that would help all the  
11 sites get there, but the first piece of that, when I send  
12 out an initiative, would have a gap analysis.

13 So if Waterbury already has all those  
14 components, they just sign off that they have those  
15 components and we're done, so that's the gap analysis.

16 I don't want everybody to do something  
17 that they've already done, or if they have something  
18 better, you know, I don't want them to go back to  
19 something we're doing, so that's the purpose of the gap  
20 analysis.

21 MR. SALTON: Once you create, fully fund  
22 and invest with staff at the corporate quality level,  
23 there's going to be some process, where you now turn to  
24 your hospitals and say, okay, we want to get a snapshot

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1 of where you are and what you're doing or not doing?

2 MS. BERRY: Correct.

3 MR. SALTON: Okay.

4 MS. BERRY: You know, how are your  
5 outcomes, comparing what you're doing with your outcomes,  
6 as well.

7 MR. SALTON: Do you perceive, as it's now  
8 laid out, like, for example, you have one data analyst  
9 laid out, that you're going to be able to get all this  
10 done for 17, 19 hospitals with the staffing that you  
11 propose?

12 MS. BERRY: I think that what we propose  
13 is a basic initial program that, as we bring in volume,  
14 we'll most likely have to expand.

15 MR. SALTON: So you'll scale it up to the  
16 volume of work?

17 MR. CROCKETT: Correct.

18 MR. SALTON: In the commitment letter you  
19 signed with Waterbury, there is a provision, this is the  
20 Late File T, I think it is, and this is my last question,  
21 so you can smile now, Mr. Crockett, there's a commitment  
22 to provide adequate financial resources to assure the  
23 facility issues related to quality and patient safety are  
24 addressed timely and not to be limited to the operating

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1 funds of the post-Waterbury Hospital.

2 I don't recall, and I don't have it in  
3 front of me, that the same commitment was made to the  
4 other hospitals. Is that commitment going to be made to  
5 the other hospitals, as well?

6 MR. CROCKETT: I believe that it was, but  
7 in the event that it wasn't, then we would make the same  
8 commitment.

9 MR. SPEES: Yeah, that one is actually  
10 slightly different and it evolved, because this was the  
11 second kind of go after, so the answer is, yes, we would  
12 be willing to do that.

13 MR. GARY HAWES: Okay. I just have a  
14 couple of questions. As you know, I do most of the  
15 charitable stuff, and we haven't had a lot of  
16 conversation about that. I only have a few questions.

17 It doesn't look like Mike is here. I'm  
18 not sure if we need him for these, because I know Mike  
19 has worked on some of this, so if you don't know the  
20 answer, then we'll just take it as a late file.

21 In looking at the new foundation, so  
22 there's a new foundation going forward that's going to  
23 handle the restricted charitable assets and any net  
24 assets that remain, in the makeup of the Board it talks

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1 about a preference or a certain number that need to  
2 either work or live in the Waterbury area to serve on the  
3 Board of this charitable foundation, and I guess my  
4 question was why will not all the trustees of this  
5 foundation either work or live in the Greater Waterbury  
6 area?

7 HEARING OFFICER HANSTED: If you could  
8 just come up to the microphone? Thank you.

9 MS. ANN ZUCKER: The thought was not to  
10 necessarily limit it to people in the Waterbury area,  
11 although that's the natural result, but to the extent  
12 that there is somebody, who perhaps had a connection to  
13 the Waterbury office and has a particular expertise that  
14 we might want to tap into, you wouldn't want to be  
15 precluded from including that person.

16 MR. HAWES: Waterbury Hospital's proposal  
17 about their needs going forward post-transaction discuss  
18 and propose, excuse me, that non-restricted funds that  
19 are coming in they're going to be used to pay off debts  
20 over time, and, so, not all of the funds that exist are  
21 going to be transferred to the new foundation right away,  
22 and, so, the question I have is how does Greater  
23 Waterbury contemplate the transactions for restricted  
24 funds happening, moving to the foundation the timing of

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1 the move of restricted funds that can't be used by  
2 Greater Waterbury to pay off their obligations, as  
3 compared to those, which can? Is it two waves of  
4 approximation actions that you're thinking about, or are  
5 you looking at the post-Greater Waterbury entity post-  
6 transaction, holding onto those and doing it all at one  
7 time once things are paid off?

8 MS. ZUCKER: We haven't made a final  
9 decision on that. It may be that we need to do two  
10 waves.

11 MR. HAWES: Okay. The summary of the gift  
12 documents and the value of the gift documents, no  
13 surprise, it's a little out of date now, so if we can get  
14 current numbers on that, and that's a request that we've  
15 made to ECHN, so I'm sure that's not a surprise going  
16 forward.

17 And not that I really have an interest in  
18 getting into community benefits or community building,  
19 but there was a report asked for for funds that will be  
20 able to continue to flow to the for-profit that's going  
21 to be reported.

22 Our office would be interested to have a  
23 report of those funds, which cannot flow to the for-  
24 profit and are going to have to have the work around, and



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1 I think the best example, I'm not going to remember the  
2 name of the fund, but the Ryan White fund and that  
3 program, so others that fall into that category how  
4 Greater Waterbury is trying to work around that to still  
5 provide that benefit, but just not through the for-  
6 profit.

7 MS. STROMSTAD: We will have that to you.

8 MR. HAWES: Okay. That's it for me.

9 MR. ZINN ROWTHORN: That's it for the  
10 Attorney General's Office.

11 HEARING OFFICER HANSTED: Okay. Before we  
12 adjourn, are there any other members of the public, who  
13 would like to give comment on the proposal?

14 Okay, with that, I would like to thank  
15 everyone, who attended this evening, and the hearing is  
16 adjourned.

17 (Whereupon, the hearing adjourned at 7:30  
18 p.m.)

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## CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 10th day of May, 2016.

  
Paul Landman  
President

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