ORIGINAL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Before I do that, I do want to say a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the official record of our review.

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

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

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

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

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

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

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

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

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

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

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

transaction. Cheryl is over here.

So, with that, thank you very much. Kevin?

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

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

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

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

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

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

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

MS. VOLPE: Okay.

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

MS. VOLPE: Okay.

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

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

MR. LAZARUS: Exhibit T.

MS. VOLPE: Okay.

MR. LAZARUS: N was --

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

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

MS. VOLPE: That took the place of N?

MR. LAZARUS: Yeah.

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

MR. LAZARUS: Yes.

MS. VOLPE: Okay. Great. Thank you.

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

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

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

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

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

the court reporter?

(Whereupon, the parties were duly sworn in.)

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

DR. CARL SHERTER: Dr. Carl Sherter.

HEARING OFFICER HANSTED: Thank you.

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

MS. DARLENE STROMSTAD: Darlene Stromstad.

MR. CARL CONTADINI: Carl Contadini.

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

HEARING OFFICER HANSTED: Thank you.

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

HEARING OFFICER HANSTED: Thank you.

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

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

HEARING OFFICER HANSTED: Thank you.

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

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

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

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

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

HEARING OFFICER HANSTED: Thank you.

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

HEARING OFFICER HANSTED: Thank you.

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

MR. RICHARD KROPP: I'm Richard Kropp,

Vice President of Human Resources.

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

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

MR. CONTADINI: Thank you.

HEARING OFFICER HANSTED: You're welcome.

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

HEARING OFFICER HANSTED: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The community foundation, a new, totally

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Their sacrifices, as well as many, many

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

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

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

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

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

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

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

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

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

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

The task force was empowered or

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

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

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

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

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

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

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

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

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

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

So our concern became will that change?

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

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

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

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

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

quality team.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

you should know that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

review over the last four years.

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

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

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

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

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

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

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

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

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

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

Which gets to what is our access to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

provider agreement at that time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

starting.

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

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

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

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

MS. BERRY: Yes.

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

MS. BERRY: Oh, sure. Absolutely.

MR. ZINN ROWTHORN: Thank you.

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

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

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

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

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

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

MR. ZINN ROWTHORN: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

I heard a lot about high reliability

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. BERRY: I was going to hand off.

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

MS. BERRY: Absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How many hospitals are part of the HCA system?

MS. BERRY: One hundred and seventy-three.

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

with immediate jeopardy termination threats?

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

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

MS. BERRY: How can I explain the regional?

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

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

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

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

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

MR. CROCKETT: Correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

The capital commitment is to be used for

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

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

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

It doesn't reduce our overall commitment

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

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

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

It's just allocated slightly differently.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, with respect to CharterCARE in Rhode

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What we're trying to do is put together an

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and what we try to do is integrate all this.

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

Mitchell, do you want to add to that?

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

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

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

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

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

DR. LEW: Go ahead. Sure.

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

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

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

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

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

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

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

That concludes our direct testimony.

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

(Off the record)

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

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

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

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

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

(Whereupon, the public spoke.)

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

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

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

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

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

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

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

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

participation level that they're currently participating in.

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

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

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

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

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

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

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

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

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

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

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

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

MR. SPEES: The Greater Waterbury Health Improvement Group?

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

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

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

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

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

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

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

MS. MARTONE: Understood.

MR. REARDON: Okay.

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

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

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

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

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

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

MS. MARTONE: Yes.

MS. VOLPE: Okay and I think we need to

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

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

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

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

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

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

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

MS. VOLPE: So this would be a new

requirement imposed on a hospital in Connecticut?

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

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

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

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

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

MS. VOLPE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

Waterbury is in the process of

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

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

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

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

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

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

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

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

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

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

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

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

MS. MARTONE: Yes.

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

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

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

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

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

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

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

MR. CROCKETT: That's confirmed, yes.

MS. MARTONE: Okay.

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

in all due respect, a total mischaracterization.

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

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

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

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

wellness and welfare to the community?

MR. REARDON: That's confirmed.

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

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

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

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

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

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

building activities, in reference to that?

MR. SPEES: Correct.

MR. LAZARUS: Okay, nothing else?

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

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

MR. SPEES: Yeah.

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

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

MR. SPEES: Correct.

MR. LAZARUS: In this instance.

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

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

MR. SPEES: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. ALEMAN: The answer is no.

HEARING OFFICER HANSTED: Thank you.

MR. SPEES: It would be a challenge.

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

DR. LEW: But a no.

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

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

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

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

MR. ALEMAN: Sure.

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

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

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

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

MR. ALEMAN: Yes.

MS. COTTO: Okay.

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

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

MS. COTTO: Post-closing.

MS. VOLPE: Post-closing?

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

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

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

MR. SPEES: Correct.

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

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

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

MS. COTTO: Okay.

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

MS. COTTO: So it fluctuates that fast?

MR. SPEES: It does fluctuate a fair amount.

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

MR. SPEES: This transaction is seven years.

MS. COTTO: Seven years for the capital commitment?

MR. SPEES: That's correct.

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

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

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

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

MS. COTTO: You are?

MS. STROMSTAD: Yes.

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

MR. ALEMAN: It hasn't changed.

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

MR. ALEMAN: That's correct.

MS. COTTO: 2015?

MR. ALEMAN: That's correct.

MS. COTTO: So it's still B?

MR. ALEMAN: B.

MS. COTTO: B-1 plus?

MR. ALEMAN: Yes.

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

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

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

MR. ALEMAN: Yeah, we can do that.

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

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

HEARING OFFICER HANSTED: Correct.

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

MR. ALEMAN: That's fine.

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

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

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

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

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

MS. COTTO: Okay.

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

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

MS. COTTO: Correct.

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

MS. COTTO: Correct.

HEARING OFFICER HANSTED: Correct.

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

MS. VOLPE: Very good.

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

HEARING OFFICER HANSTED: We're all set.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. CROCKETT: That's correct.

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

DR. LEW: Yes.

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

You want the names? One is Candace Peters.

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

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

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

MS. BERRY: Yeah.

MR. SALTON: Okay.

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

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

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

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

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

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

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

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

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

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

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

MS. BERRY: Um-hum.

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

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

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

MR. CROCKETT: That's acceptable.

MR. ZINN ROWTHORN: Thank you.

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

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

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

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

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

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

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

MS. BERRY: Correct.

MR. SALTON: Okay.

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

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

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

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

MR. CROCKETT: Correct.

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

funds of the post-Waterbury Hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. STROMSTAD: We will have that to you.

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

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

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

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

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

AGENDA

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

Post Reporting Service
1-800-262-4102